ISSUE PAPERS

SOUTH CAROLINA
WHITE HOUSE CONFERENCE ON AGING

April 25-27, 2005

Springmaid Beach
Myrtle Beach, South Carolina

Lieutenant Governor's Office on Aging

SOUTH CAROLINA
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(A)
Housing

Issue Papers

Atlantic C

Basic Home Modifications for Those Desiring to Age in Place

By

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Basic Home Modifications for Those Desiring to Age in Place

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Description of the issue

As a person grows older his/her needs and limitations evolve in respect with the suitability of one's home. Whether it is restricted mobility due to arthritis, poor vision from cataracts or a loss of security due to the death of a spouse…These changes can typically be addressed by resolving to psychologically accept them, seeking advice from well intentioned experts, and making the recommended improvements in a timely fashion.

Common barriers

The most common road block to making improvements is that the person living there does not accept the fact that they have a problem. At times, the impediment could be a spouse or an adult child that is a decision maker. Accepting that there are issues to be dealt with and resolving to move forward is paramount in having one's surroundings be as safe and comfortable as practical.

Economics can play a major role in limiting the access to home improvements. Remodeling and repair work is as expensive as it ever has been, and will continue to escalate with both material and labor costs ratcheting upward. However, there are many modifications that can be done on a budget.

Because access to experts who perform specialized modifications may seem difficult, people tend to be shy about seeking advice for fear of being seen as ignorant or vulnerable. This is especially the case when the spouse who handled all the home maintenance issues passes away leaving the surviving spouse to carry on. Fortunately, there are resources available to help.

Solutions to overcoming barriers

For those persons who realize the need to make changes…They are already ahead of the game. For those persons who don't want to, or can't recognize the need for change then they need the assistance from someone in their support system. Alzheimer's patients can be a challenge in this scenario, particularly in the absence of a care taker.

Once needs are identified, prioritized, and priced from reputable contractors…Then an overall budget plan can be assembled. Different sources of funding for this type of work include reverse mortgages, home equity loans, savings/investments, and family members. There are some government and private grants available, but the access can be limited. Again, a family member or supporter may need to be involved in some or all of this process.

Identifying, establishing rapport, and hiring the right contractor for this type of work is something that should be easy, but often becomes a stumbling block. The most important traits to look for when hiring a contactor are honesty and experience. Professional contracting associations, referrals from family and neighbors, and care givers can assist in referring a reputable contractor. It is important to identify a contractor that is experienced in this type of work and has a wide range of capabilities.

Specific actions that can be undertaken to implement the solutions

Ask a Certified Aging in Place Specialist (CAPS) contractor or a barrier free consultant to evaluate (also called a Home Audit for Independence) your home's suitability to accommodate one's existing physical condition. Future health conditions should also be considered. This evaluation process is usually done for a nominal fee and most professionals will credit the fee against future services. As many decision makers as possible should be present for such an evaluation, I.E. spouse, children, etc.

Once an evaluation has been completed, then the process of establishing a budget can begin. Ask a few contractors to review the evaluation list, and get written contracts to perform the work. Some common improvements include:

1. Widen parking spaces so that there is a min. of 36" to the sides of the vehicle. Fall prevention.
2. Adding stair rails at all entrance steps. Fall protection.
3. Ensure stairs have non slip surfaces and closed risers. Fall prevention.
4. Ensuring that your street address number is visible from the street…even at night. Security.
5. Installing a peep hole in the front door. Security.
6. Re-keying all your door locks for the same key. Manual dexterity.
7. Exterior lights should have multiple bulbs and controlled by a photo cell. Security. Fall prevention.
8. Pruning shrubs near doors and windows to eliminate hiding places. Security.
9. Replacing thick pile carpet with low cut type. Trip hazard.
10. Increasing the amount/brightness of light fixtures. Vision.
11. Raise washer and dryers atop a platform. Spine injury prevention.
12. Replace shower/tub valves with pressure balanced type. Anti-scald for blood circulation.
13. Adjust water heater to reduce maximum temperature. Anti-scald for blood circulation.
14. Ovens with side opening doors. Applicable for wheel chair users.
15. Stove tops with front mounted controls. Applicable for wheel chair users.
16. Glass front wall cabinet doors in the kitchen. Helps those with memory problems (Alzheimer's patients).
17. Comfort height commode. Universal.
18. Lever door hardware and faucet handles. Universal.
19. Large rocker switch for light fixtures. Universal.
20. Grab bars in bathing areas. Universal.
21. Shower/bath seats. Mobility issues.
22. Graspable railings at all stirs. Fall prevention.
23. Widen doorways to a min. of 32" where possible. Wheelchair and walker access.
24. Eliminate thresholds where possible, or at least provide a transition. Mobility.

The contractor should provide a written contract detailing the specifications, how change orders are dealt with, the price, a payment schedule, warranty, and reference the contractor's building license number. Lastly, you'll want written confirmation of up to date worker's compensation and general liability insurance. Remember to get plenty of recent referrals. Do not always go for the lowest price. Do you trust the contractor? Remember, that you get what you pay for.

Making changes to improve the suitability is a smart move especially when done in a timely fashion. In some situations improvements may be so costly that consideration should be given to relocation to an institutional type setting. Whether one decides to age in place or relocate to an institution…My best advice is to be proactive in addressing the issue before it becomes too late.

Non Subsidized Housing

By

Roger Owens
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White House Conference on Aging

Topic: Non Subsidized housing
Presenter: Roger Owens
Issues: 1. Affordable Housing for the increasing population of seniors.
2. Reaching seniors with information about affordable housing.
3. Educating seniors not to stay isolated at home.

Barriers to Cross

A. High Cost of senior housing.
B. Independent senior housing no longer nursing home.
C. Seniors staying home too long alone.
1) The house they have lived in for 50 years is more important than health safety or companionship.

Solutions to overcoming barriers

A. Tax incentives for companies that are building affordable senior apartments or housing.
1) Property tax incentives for cost effective senior apartments or housing.
2) Educate seniors on differences in different types of senior housing.
a. Full buy in
b. Month to month
c. Assisted living
d. Nursing homes
3) Don't wait too long before nursing home is the only alternative.
4) Living in a senior community with 3 healthy meals a day, exercise, companionship, eliminates isolation and depression.
a. Creates healthy, active and happy seniors.

Recommendations

A. Encourage more affordable senior housing.
1) State and Federal incentives to encourage companies to develop and finance better senior apartments and housing.
a. Tax incentives
b. Property tax incentives
c. Utility cost incentives such as given to industry.
B. Informing seniors about active senior complexes and lifestyles.
1) State and Federal pamphlets on healthier life styles.

Roger Owens

a. Promotes better physical bodies and mental attitudes.

2) Church groups become more active informing their seniors about active senior communities and other senior housing rather than staying isolated in their homes.
3) Universities institute classes and labs for their students to partner with seniors and study active lifestyles vs. inactive life styles and what motivates the better lifestyles.

C. A healthy active independent senior is a well-adjusted and well-rounded senior

1) Public health network promoting an aggressive partnership to teach and make available "how to" ideas on healthy lifestyles.
2) Active seniors are healthy and cost less to keep health,over 500 million dollars a year is spent by the State on senior health care.
   a. Over 242 million dollars spent on obesity related costs.
   b. Area Senior Centers partnership with Senior Housing to fill gaps for needed activities and socializations.

The Changing Face of Public Housing and How It Will Play a Role in Housing Older Adults in the Future

By

Donna Jones-Gilbert
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Columbia, South Carolina

Issue statement:

The Changing face of public housing and how it will play a role in housing older adults in the future.

Donna Gilbert

Public assisted housing, that is, housing built and maintained largely or entirely with public funds plays an indispensable role in meeting the
needs of older adults. It is an incontrovertible fact that the private housing market, left to its own devices will not provide adequate
housing for that sector of our population. Public housing authorities Section 8 and other subsidies were brought into being because their proponents had serious concerns about the availability of safe adequate housing for the poor, elderly and disabled. This is a sober attempt to address a set of very real future challenges. For my part as a practical manager, developer & citizen, I feel it is my mission to design housing and programs that will enrich the entire society by providing independence and dignity to seniors. Without publicly assisted housing, just as without social security and adequate retirement income, seniors who are lucky enough to have someone willing to house them, will be thrown back upon the families of their adult children. Many of these families are struggling with children of their own as well as their own disproportionate spending to actual income. Any diminution in the supply of available publicly subsidized and assisted housing is therefore bound to cause a general and significant decline in the living standards of families who will be forced to take in their non-working parents. Without an increase in the supply of assisted elder housing given the predicted changes in the demographic curve, we will eventually see something that we have not seen in six or seven decades …that is at worst "homeless seniors" and at best, seniors in overcrowded, substandard or inadequate housing.

That said, There are two key areas that could enhance my ability to develop, adapt and build more elder designated units are 1) New Universal Housing codes and programs (for new construction and renovations) 2) Shifting and/or Relaxing of Social Policies and The Development of reimbursement and subsidy programs that will offset the cost of adapting existing structures.

The US Department of Housing and Urban Development pays for construction and some of operating costs of public housing units for low income people. These public housing projects are operated by over 3300 local public housing authorities throughout the U.S. We the developers in local housing authorities operate and administrate facilities for people for all ages. These facilities are sometimes in part or entirely dedicated for the elderly. Over the past few years federal funding has dramatically decreased and in response to this reduction some states have created a range of innovation cost effective housing options and partnerships. Even with these innovations I feel that there are still major barriers to building elderly designated new units to meet the demands of the changing population. One in particular is the building cost driven by the emphasis to meet Federal Accessibility standards. While I admit that there must be good standards in place to ensure that our older citizens are housed in safe, barrier free, appropriate affordable housing. More steps need to be taken to make sensible, cost effective standards with incentives on new construction. Due to the emphasis HUD has placed on housing subsidies and vouchers the trend has moved away *from* new construction. *"Older people can use the Section 8 certificate program to seek an affordable barrier free housing unit. In 1983, a housing voucher program was created which is similar to the certificate program; however; the actual rent is negotiated by the tenant and landlord and amount of subsidies ……roughly 46% of the program funds were for elderly or handicapped individuals." (Dunn, Peter A. 1997)*

Having witnessed the enormous shifts in the economy over the last few years, I understand the need for the government to employ more conservative policies in funding however having managed through dramatic reductions in residents programs, I am concerned that reductions in federal elder programs coupled with the complexity in processing and/or qualifying for partial funding will make building

facilities almost an impossible venture for a non profit. Without some creativity here in Medicare/Medicaid policies designed for housing, elder housing will become the step-child of public housing. *"Medicaid is not one program, but 50 different programs that states administer using broad federal guidelines……. Medicare is a federal program that provides health care for some 41 million senior citizens and retirees over 65 years of age. Until recently, states had no role in Medicare. Starting Jan. 1, 2006, Medicare will provide a prescription drug benefit for the first time, but Medicaid costs still are expected to eat up state budgets. The rising health care costs, particularly prescription drugs, play a huge role, but so do demographics." (Prah, Pamela. 2005)*

The answers for the "how to" in building more facilities devoted to low and moderate income elderly public housing could be found at the state level through a reworking of Medicaid/Medicare restrictions as well as tax credits and relief to the elderly in light of the burden prescription drugs have on fixed incomes.

"As Americans gets older, many will need more long-term care and nursing home care. Medicaid already is the nation's primary long-term care program, accounting for 43 percent of total long-term care spending and paying for nearly 60 percent of nursing home residents unlike all other Medicare services, states will partly pay for this benefit." (Prah, Pamela. 2005)

We have all heard this adage made popular recently by Hillary Clinton, a billion times, "It takes a village" ……In keeping with this thinking, I feel that city, local and federal governments along with key members of the for profit private industry should develop cooperative ventures that will work together in developing alternative funding earmarked especially for housing and care for the aged. Funding alone is not the single answer to this challenge. There should be some consideration in our cultural perspective as to how our value and treatment of the elderly

Active seniors are workers, volunteers, mentors, grandparents and productive citizens. Public assisted housing keeps them this way. Take it away and they will be dependents, living shorter, sicker lives and we will all be the poorer for it.

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Responding to the Need for Affordable Housing in Our Aging Population: A Role of Non-Profit Organizations

By

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RESPONDING TO THE NEED FOR AFFORDABLE HOUSING IN OUR AGING POPULATION : THE ROLE OF NON-PROFIT ORGANIZATIONS

Volunteers of America of the Carolinas, Inc. (VOAC) is one of the largest non profit providers of housing and other supportive services for homeless and modest income persons in the Carolinas. VOAC provides hope, support and social services to communities, families and individuals. Our mission is to recognize each one's dignity, empower people to achieve their goals and realize their potentials. Affordable rental housing and supportive services, child development services for homeless and other at risk families, and transitional housing with intensive services for homeless families are some of the programs provided in twenty-five communities within the Carolinas. VOAC is an affiliate of Volunteers of America, Inc., a national organization founded in 1896, with a presence in 40 states, and a rich history of providing affordable/assisted housing opportunities for the past thirty-five years.

Our experience in developing and providing housing services to modest income seniors – both nationally and here in the Carolinas – has given us first hand knowledge of the need, the barriers, and the rewards. The need is almost incalculable, and growing – as the population is aging and as the cost of housing continues to grow. Our housing serves seniors whose income is below 50% of the median income in their area. This is proscribed by the funding that is made available for development of these apartment communities. That simple description of what we do actually embodies several of the most difficult barriers to offering safe, decent, affordable housing for modest income seniors:

1. First, and foremost --- The need for this type of rental housing is far greater than the current availability. Simply put – there are not enough apartment communities/units on the ground today to meet the need. The waiting lists are typically quite long.

2. The funding designated for affordable housing is finite annually and unfortunately, the only source specifically designated for seniors has been cut over and over again in the federal budget. Currently, South Carolina is fortunate to see two new senior apartment communities totaling less than 100 units awarded through the HUD Section 202 Elderly Housing program each year. Other funding such as Low Income Housing Tax Credits and Bond financing also add some units. The level of competition in the current 2005 SC tax credit program gives you an idea of the shortage of funding. There are 72 applications; likely one third of those will actually receive an allocation that will allow them to raise the investment dollars to build their proposed apartment complex. More specifically to our focus today, you need to know only 13 of those applications propose to serve seniors.

3. While 50% of median income is the maximum amount allowable for most of the seniors we serve – that is by no means the typical income for our residents. It is much more prevalent for them to be at below 30% or even below 25% of the median income for areas of SC like Charleston, Beaufort, Greenville, Columbia metropolitan area. That is because they are on a modest fixed income that is at the level of SSI. They often spent all their careers in what were solid manufacturing and service industries, but now find that their income in retirement will not keep up with the rising cost of living. And we find it is simply not possible to build and operate apartments at a cost that is affordable to seniors who often make less than $7,000 per year. They are able to pay about $150 per month using the HUD definition of 30% of their adjusted gross income. We have found that the lowest possible rent for a one bedroom senior unit is going to exceed $300 per month no matter where it is built in SC., even if there is no permanent debt service on the property. Rental Assistance payments are critical to making it possible for most of these seniors.

And that is the major barrier – rental assistance is not available at a level to meet current needs – and is under attack for more cuts. Without it, vast numbers of seniors.

So, I present that these are the 3 most difficult barriers to providing good safe affordable housing for seniors: lack of supply, inadequate funding for building/creating additional units and inadequate supply of rental assistance for seniors with very, very low incomes. These are barriers that can be overcome; it will take continued creative programs such as the tax credit program that encourages the private sector to invest in affordable housing. The result is measurable: many, many more seniors live longer vibrant, productive lives, contributing to their communities in a variety of ways. Just one example is a strong volunteer program that is organized and carried out by the senior residents, in one of our communities – that offers services within the apartment complex and to seniors in the surrounding neighborhood. So, of course, this housing is a benefit to the residents.

It is also a cost effective alternative to what are all too often the only remaining choices that are more restrictive – nursing homes, board and care facilities, etc. These are not inherently bad; there just need to be more options for people to live independently in safe, decent and affordable housing communities, designed to allow them to age in their own home and stay engaged within the larger community. Volunteers of America has been and will continue to be an advocate for this vision.

Community Forums Report

(A)
Housing

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

HOUSING

LOCATION OF EVENT: Florence Civic Center – Florence, SC

Priority Issues:

A) Housing affordability and availability
B) Residential design, including home modification relating to safety and convenience
C) Urban vs. Rural

Proposed Solution:

A) As the oldest-old continue to live longer, their need for Older Americans Act (OAA) services will continue to increase. To provide for a functional living environment for an aging America, we must prepare now to meet this increased demand, especially in the area of housing. Recognizing the benefits of providing an opportunity for seniors to remain as independent as possible, one of the biggest concerns for the future is the availability and affordability of manageable housing.
B) Not all seniors will want to live in planned communities; however, this option needed to be available for those who want it. While continuing care retirement communities are not widely available, they provide the privacy of independent living as well as long-term care; all under one "roof". We recommend the availability of a variety of housing options serving people of moderate and middle incomes, ranging from single-family communities and service-enriched senior communities (i.e., planned, secure communities with shopping and recreation in the area) to continuing care retirement communities. We support an increase in private-public partnerships to increase functional housing in urban and rural communities across the region.

LOCATION OF EVENT: City Council Chambers – Rock Hill, SC

Priority Issue:

Housing needs for seniors larger than the availability of affordable housing.

Barriers:

1) Accessibility in housing; need more handicapped accessible housing.
2) Short supply of homes for single family or handicapped seniors.
3) Non-existence of housing in the moderate price housing. This affects middle-income retirees.

Proposed Solution(s):

(MISSING!!!) – NOT INCLUDED IN PACKET.

LOCATION OF EVENT: Santee-Lynches Regional Council of Governments – Sumter, SC

Priority Issue:
Older people want to age in place, however, without funding for home repair, rehabilitation or modification, they will be forced to leave their homes.

Barriers:
1) Insufficient housing program funding.
2) Seniors on fixed income.
3) Seniors physically cannot make repairs.

Proposed Solution(s):
1) Advocate fore more program funding.
2) Encourage the use of home modifications that extends the functional capacity of the unit.
3) Community response to meet needs to include faith-based community.

LOCATION OF EVENT: Emmanuel Baptist Church – Manning, SC

Priority Issue:
Seniors' ability to afford needed home repairs.

Barriers:
1) Need more money for rehab housing.
2) Lack of contractors who work for less or will work on smaller jobs.
3) Income qualification issues.

Proposed Solution(s):
1) Use federal taxes at home first, not in other countries.
2) More community involvement with home rehabilitation/repairs (volunteers, youth help, and church assistance).
3) Broader communications in the community.

LOCATION OF EVENT: Kershaw County Health Resource Center – Camden, SC

Priority Issue #1:
Home repairs.

Barriers:
1) Many seniors live in deteriorating homes or older mobile home units that need repairs.
2) Seniors don't want to move; they desire to age in place.
3) Lack of affordable home repair service providers.
4) Waiting list for repair assistance far too long.

Proposed Solution(s):
1) Increase Community Development Corporation involvement.
2) Provide more funding for home repair and rehab of homes for seniors.

Priority Issue #2:
Lack of affordable housing options.

Barriers:
1) Many seniors have a limited income to get adequate housing. Some seniors at risk for becoming homeless. Average income level of seniors not consistent with adequate affordable housing.
2) Homeless populations are increasing.
3) Lack of affordable housing for those with disabilities.
4) Limited income individuals are forced to deal with high interest predatory lenders.
5) High down payments and closing costs prevent many seniors from obtaining adequate housing.
6) Lack of financial management counseling for seniors.

Proposed Solution(s):
1) Build safe, affordable housing for seniors and those with disabilities.
2) Attract higher paying jobs/industry to this area in hopes that seniors can obtain work to increase their income.
3) Promote utilization and awareness of state and federal low interest loan program; make more people aware of predatory lending institutions and eliminate use of predatory lending institutions.
4) Provide financial management counseling to seniors.

Focus Group Concern: Lack of transitional housing for homeless and for those finding themselves in emergencies and need temporary housing.

LOCATION OF EVENT: The Shepherd's Center – Sumter, SC

Priority Issue:
Safe, affordable, accessible, decent housing options for all people.

Barriers:
1) Lack of appropriate units, both rental and homeowner.
2) Lack of Section 8 and 202 voucher funding (federal and state).
3) Lack of funding oversight.
4) Lack of awareness, marketing, and advocating.
5) Lack of knowledge of universal design concepts.
6) Not enough people available to do repair or rehab work.
7) Seniors often feel vulnerable and unable to trust home repair workers.

Proposed Solution(s):
1) Better access to opportunities for Section 8, 202 vouchers.
2) Prioritization of assistance for special needs population.
3) Advocate for increased funding.
4) Review current voucher system.
5) Develop a cadre of bonded providers/contractors that are available to do repairs and/or rehabs.

LOCATION OF EVENT: Bethlehem United Methodist Church – Bishopville, SC

Priority Issue:
Need for affordable housing for rising number of seniors.

Barriers:

1) Lack of available funding.
2) Convincing seniors to move to complexes.
3) Lack of family support for such complexes.

Proposed Solution(s):
1) Apply for federal grants.
2) Train seniors on awareness and options available to them.
3) Train family members on options available to their loved ones.
4) Renovate existing homes to meet senior needs.

Focus Group Concern: (1) Housing security and safety needs of seniors, and (2) Availability of fitness centers for seniors in housing complexes.

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
Affordable housing for seniors.

Barriers:
1) Personal finances.
2) Housing that is not accessible for seniors.
3) Affordable housing.

Proposed Solution(s):
NOT ADDRESSED IN PACKET.

South Carolina
White House Conference on Aging

April 25-27, 2005

(B)
In-Migration

Issue Papers

Carolina A

Cost Benefit of In-Migrating Families and Retirees

By

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2005 South Carolina White House Conference on Aging

Working Issue Paper:
Cost Benefit of In-migrating Families and Retirees

Organized by
Patrick Mason, Co-founder, Center For Carolina Living (**Pmason@CarolinaLiving.com**)

ISSUE:

- How in-migrating retirees impact the SC challenge to create a sustainable quality of life.
- How do we efficiently increase the tax base.
- How can we fuel the economy with new housing starts.
- How do we attract and retain affluent retirees, nurses, teachers, IT professionals, entrepreneurs, venture capitalists and volunteers.
- How do we improve the education funding structure and its delivery process.

FISCAL IMPACT: Facts About In-migrating Families

- For every retirement household established, at least one-half a job is created in the local economy, according to the USC study. (The NC study reported 1.5 jobs.)
- Thoughtful estimates predict S.C. will receive 145,000 (gross) newcomers in 2005.
- 43% are over age fifty in some stage of retirement decision.
- 100% come as visitors first, making our Tourism Industry the "birth-mother" of our in-migration industry.
- Their average house hold income is $110,000 according to Clemson research.
- 83% come with college graduate credentials according to Center For Carolina Living surveys of 37,500 families since 1987.
- 90% of the time at least one person in the household seeks employment. (Note that a third of the 5,000 residents of Sun City are on a payroll.)
- 14% will start or move a business.
- Of the estimated 30 million SC visitors in 2005, an estimated 6% are actually here for the primary purpose of investigating retirement or relocation or second home opportunities.
- The private sector residential industry spends at least $20 million annually to attract out-of-state families (tourists) to tour their SC properties.
- SC Department of Tourism spends a fraction of that and does an excellent job generating 800,000+ orders for our Vacation Guide.
- SC is one of the few states offering a first class Relocation & Retirement Guide backed up with a rich content web site: www.Carolinaliving.com.
- Our #1 competitor, Florida, eats S.C. tourism and relocation lunch daily and Jeb Bush recently completed a comprehensive cost benefit study measuring the impact of retirees FL. (The FL, AZ, and LA studies have all measured a significant net positive impact.)

OVERCOMING THE BARRIERS… IDEAS FOR ACTION:

A. Petition the SC Legislature to fund a two-panel research study:
   1) A cost benefit economic impact study on in-migrating retirees.

2) An economic impact study on the residential community/home building industry. (Estimated cost for both panels, $150,000.)

B. Allow the private sector (CFCL and the residential community home builder industry) to acquire a multi-page editorial section and reader response card inside the SC Vacation Guide to showcase the benefits of living, working, doing business and retiring here. Have the PRT web site include the same article online.

C. Ask two or three additional questions when taking orders for the SC Vacation Guide with this data collection to be paid for by the private sector:
   1) Is your family considering retirement, relocation or buying a second home in SC?
   2) Will anyone in your household be seeking employment here?
   3) Are you planning to start a business as part of your relocation?

   Responders fitting the "yes" characteristics will be served with a complementary copy of the Official Carolina Living Guide and information on starting a business.

The Advantages

- In-migrants increase the tax base.
- Boomer in-migrants help fund education and do not have children in schools.
- Half will build a new home.
- In-migration creates a rich stream of entrepreneurs and skilled volunteer talent.
- The private sector will fund this program with in-kind cooperation from PRT and Commerce.

Gray Gold

By

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GRAY GOLD

Gene Warren, President and CEO
THOMAS, WARREN + ASSOCIATES

Issue

A question being heard with increasing frequency in states like South Carolina that have significant numbers of retirement-age individuals (those over age 55) moving into their state is: "Are retirees paying their way?" In light of this question, the State of South Carolina is considering its position on the issue of promoting or facilitating the in-migration of people for the purpose of retirement.

Barriers

There are a number of perceived myths (barriers) that discourage a state from promoting itself as a retirement destination. However, recent research by THOMAS, WARREN + ASSOCIATES[1] has dispelled many of the myths associated with retirement-age individuals, especially those myths that characterize retirees as burdens on society.

Myth 1: Retirement-age individuals have below average incomes.

- The per capita incomes of retirement-age residents of Florida were 114% of the state's 18-55 year old residents in 2000.
- The per capita incomes of Louisiana's retirement-age residents were 127% of the 18-55 year old residents in 2000.
- The per capita incomes of Arizona's retirement-age residents were 120% of 16-55 year old residents in 1996.

Myth 2: Retirement-age in-migrants impose a burden on the state.

- In 2000, the average incomes of retirement-age households moving to Florida were estimated to be nearly the same as that of those aging-in-place.
- In 2000 the average incomes of retirement-age individuals moving to Arizona were estimated to be 2% higher than those aging-in-place.
- In 2000 the average incomes of retirement-age individuals moving to Louisiana were estimated to 13% higher than those aging-in-place.

Myth 3: Retirement-age individuals spend less than their younger counterparts.

- Retirement-age residents of Florida comprised 28% of the state's population in 2000, but accounted for 48% of its consumer spending.
- Retirement-age residents of Louisiana comprised 20% of the state's population in 2000, but accounted for 38% of its consumer spending.

1. "The Impacts of Retirement-Age Residents of Arizona," (1998), "The Impacts of Mature Residents of Florida," (2002), and "The Impacts of Retirement-Age Residents of Louisiana," (2002) may be accessed at www.twaaconsulting.com.

- Retirement-age residents of Arizona comprised 21% of the state's population in 2000, but accounted for 34% of its consumer spending.

Myth 4: Retirement-age individuals do not support schools.

- Retirement-age residents of Florida were 28% of the population in 2000, but paid 47% of the residential property taxes.
- Arizona's retirement-age residents paid 139% more per capita in residential property taxes in 1996 than did residents under the age of 55.
- An Arizona survey of 900+ retirement-age individuals conducted in 1996 found that 71% of them who said they voted also stated they voted in favor of school bonding issues.

Myth 5: Retirement-age residents get more than their fair share of a state's public health benefits.

- Medicare and the federal portion of Medicaid spending is a benefit to a state.
- In 2000, per capita, state funded health expenditures in Florida were nearly the same for retirement-age residents as it was for residents under age 55.
- In 2000, Florida's Department of Elder Affairs spent $858 per client, but only $23 per retirement-age resident.
- In 1996, AHCCCS (Arizona's Medicaid) spent more on maternity care than it did on its retirement-age residents.

Myth 6: A state's retirement-age residents do not pay their way.

- In 2000, retirement-age residents of Florida paid 85% more per capita in state taxes than did residents under age 55.
- In 2000, retirement-age residents of Louisiana paid 49% more per capita in state taxes than did residents under age 55.
- In 2000, retirement-age residents of Arizona paid 21% more per capita in state taxes than did residents under age 55.

Myth 7: Public funds spent to attract retirement-age individuals only subsidize developers.

- Net economic benefits (taxes less health care costs) to states from retirement-age residents:
  - Arizona $306.8 Million in 1996
  - Louisiana $319 Million in 2000
  - Florida $1.42 Billion in 2000
- Jobs attributable to retirement-age residents' spending:
  - Arizona 150,000 in 1996
  - Louisiana 47,600 in 2000
  - Florida 420,000 in 2000

Myth 8: Popular retirement destinations are over run with retirees.

- Top 5 states in percent of individuals age 65 and older in 2004:

Florida	16.83%
West Virginia	15.33%
Pennsylvania	15.29%
North Dakota	14.80%
Iowa	14.73%

- U.S. 12.35%

- Others

Arizona	12.80%	(ranked 26th)
South Carolina	12.40%	(ranked 29th)
North Carolina	12.09%	(ranked 34th)
Louisiana	11.66%	(ranked 40th)
Georgia	9.59%	(ranked 49th)

Myth 9: Attracting retirement-age residents changes the nature of a community

- Retirement-age individuals generally have a choice of where to live.
- Retirement-age individuals self select retirement communities that match their desired lifestyles.
- Retirement-age individuals match community amenities with their preferences, thus only strengthening the community's existing nature.

Myth 10: Today's retirement-age individuals view retirement like their parents.

- According to Richard Florida, unlike their parents, the current trend with baby boomers is that many more of them want to be integrated into mixed age communities.
- Traditional relocation patterns are changing:
  - The rate at which retirement-age individuals are moving to traditional retirement states is decreasing (*e.g.*, from 2003 to 2004 the percent of Florida's population age 65 and older dropped from 17.02% to 16.83%).
  - TW+A estimates that baby boomers are less than half as likely to move into age restricted communities as were their parents.

Myth 11: Retirement-age individuals are not involved in their community.

- Like their parents, today's seniors remain involved with their church, with social service organizations, and with political campaigns.
- Florida's retirement-age residents gave $3.6 billion to charity in 2000 compared to the $2.2 billion given by more than twice the number of younger residents.
- Retirement-age individuals tend to be more supportive of the arts and cultural activities than are younger residents.

Workable Solutions

Based on the above facts the answer to the question, "Are retirees paying their way?" is yes, but not unequivocally yes. The THOMAS, WARREN + ASSOCIATES studies found that, *on average*, retirement-age individuals have higher per capita incomes, spend more per capita, and pay more in state and local taxes than their younger counterparts. Further, *on average* these additional taxes cover any additional costs of state funded medical care required by retirees. The key phrase here is "*on average*." While most retirement-age individuals are not imposing a burden on their state of residence, some are.

This raises the question of what to do about those who are not paying their way. They can't be denied residency. They can't be denied access to the medical services they need. One obvious solution is to discourage less affluent retirement-age individuals from moving into the state. This, of course, begs the question of how to accomplish that? Retirement-age individuals moving into a state, whatever their financial resources, can't be given less or

lower quality medical care than other residents. They can't be denied any of the rights of other, current residents.

A more realistic solution is to recruit resourceful (affluent) retirement-age individuals to offset the burdens imposed by the less resourceful ones. According to U.S. Census data, the household incomes of most migrant retirement-age individuals into Sun Belt states are higher than those individuals aging-in place. In South Carolina this difference was a little over $8,800 per year in 2000. This translates into retirement-age in-migrants to South Carolina having incomes about 20% higher than those South Carolinians who are aging-in-place. Based on the results of the impacts of retirement-age residents of Arizona, Louisiana, and Florida, it is plausible that the additional taxes paid by these more resourceful, retirement-age migrants will cover not only any costs they may impose on the State, but also the State funded medical expenses of the less affluent individuals.

Thus, a state recruiting resourceful retirement-age individuals to move there will ensure that, on average, retirees will not become a burden on a state's younger residents. The bottom line is that retirement-age residents provide tremendous net economic benefits to the political entities in which they live. Their spending provides a more than proportionate share of the fuel for the economic engine and creates a wide variety of jobs for younger residents. Further, to the extent that their income is provided by pension plans (either social security or private plans) their spending is not as affected by fluctuations in the economy as is the spending of jobholders. Thus, they provide stability in both spending and employment. Finally, because the taxes they pay exceed the public expenditure they receive, they, in effect subsidize their younger counterparts. For all these reasons it is evident that retirement-age individuals are truly "gray gold" to the cities, counties, and states in which they live.

Recommendations

South Carolina should evaluate the benefits and costs of in-migrating retirement-age individuals to the state and formulate state policy accordingly.

- Mitigate burdens imposed by less resourceful retirement-age individuals.
- Ensure that retirees are receiving a fair share of the state's resources.
- Recognize that the attraction of retirement-age residents is a very effective type of economic development.
- Consider impacts on South Carolina's residential and commercial construction industries.
- The attraction of retirement-age individuals should be linked to tourism because:
  - No one retires someplace they haven't visited, usually 3 or 4 times.
  - Senior retirees are essentially tourists

In-Migration and Its Economic Effect on South Carolina

By

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IN-MIGRATION AND ITS ECONOMIC EFFECT ON SOUTH CAROLINA

By: Mitchell C. Payne
Warner, Payne & Black, L.L.P.

"Beautiful Places, Smiling Faces", yes it is true South Carolina has a national reputation as being a friendly place to live. Bolstered by its warm climate, historic cities, and beautiful coast, South Carolina seems destined to see a continuing upswing in the inflow of people from other areas of the country and perhaps the world. This inflow will present both benefits and burdens for our state.

The First Wave:

The most rapidly growing segment of American society is the over 65 population. Further, due to rapid rate of advancement in health care, this population is retiring healthier than ever. Consequently while in the past retirees have sought to retire near family and friends who would assist them in their old age, today's retiree's are increasingly looking for warm climate, activities, and beautiful surroundings. These goals make South Carolina an ideal retirement destination for this group.

These facts have not gone unnoticed by economic development forces. A stated goal of Governor Mark Sanford's efforts to cut the state's income tax rate is to attract wealthy seniors. The Governor and others believe an influx of wealthy retiree's will provide stimulus to the state's economy and produce needed jobs to offset the massive outflow of manufacturing jobs from our state to cheap overseas labor markets. However, if we look to Florida as an example, we see that as South Carolina becomes an increasingly popular retirement destination we will attract retirees from all segments of society; i.e. wealthy, middle class and poor, and the ultimate mix of the group will determine the positive or negative impact of this group on South Carolina.

First Wave Opportunities:

The opportunities associated with an influx of seniors into South Carolina are obvious. Those over the age of 65 hold a disproportionate percentage of the wealth in this country and, because they have leisure time, spend more on leisure activities than the average 45 year old. An influx of new people spending money will mean more businesses which should translate into more jobs. In addition, as they buy real estate, the value of real estate should go up in certain areas of the state leading to more property tax revenues. Further, senior citizens do not add significantly to the burden on local governments as they do not need schools for their children and do not increase the local crime rate.

First Wave Burdens:

There are however, risks associated with a large influx of new older residents. While new retirees are healthier than they have ever been, that health does not last forever. As we age we suffer illnesses at an increasing rate. Any state whose demographics is skewed toward seniors can expect ever increasing pressure on its medical infrastructure. A higher percentage of seniors in the state's population mix means a need for a higher number of doctors, per capita, a higher number of hospital beds, and a higher number of nursing home beds, per capita.

Also, while most seniors have some form of insurance, some have only medicare, which does not pay the entire bill for their care. Seniors in this situation frequently have no ability to pay the amount not otherwise covered by their medicare. To complicate the matter further, Medicare frequently pays lower rates than private insurance for medical services. This may initially result in an increase in the cost of medical care for those not on medicare; which will put pressure on the profits of local businesses as they traditionally pay the cost of insuring employees.

Then there is the issue of long term care. As medicare does not pay a significant portion of the cost of long term care (i.e. nursing home care, assisted living, and at home care for the severely disabled) and as most senior citizens do not have long term care insurance any state with a disproportionate share of senior citizens should expect an increasing need for adequate long term care facilities, and home based services. As we discussed above, more and more seniors live far from their families and friends. Many seniors cannot expect their children to assist in their care as their children are busy providing for their spouse and children. Consequently many seniors will need to look to institutions and home health services for care if they become unable to care for themselves.

While South Carolina may be attempting to influence "wealthy seniors" to come to our state to retire, the issue of who is wealthy and who is not takes on an entirely different tone when one starts to consider the cost of long term care. The average cost of a nursing home in SC, excluding the cost of medicine and ancillary services, is approximately $4,200 per month. In our experience when you add in medicine and ancillary services the cost is closer to $4,500.00 per month, and this is increasing at a rate above the normal inflation rate in the economy. Many seniors, especially those with a spouse to support, simply are incapable of paying this level of expense on a monthly basis. Thus they will be looking to the state for help. The only program we currently have in place for assistance with long term care costs is medicaid.

The need of seniors for help in the long term care arena is significantly complicated by the fact that senior benefits are currently under attack in Washington. The current administration feels the need to cut government sponsored health care benefits; especially those flowing to senior citizens. Again, any state whose population mix is disproportionately older will suffer if medicaid benefits from Washington are cut.

As most are aware, medicaid benefits for long term care are paid partially by the federal government and partially by the state. Each state receives a varying percentage of the cost of medicaid depending on the states need. Currently SC is one of the states where the federal government pays a higher percentage of the cost of medicaid than does the state. Consequently, long term care costs actually stimulate economic growth in this state as the capital flowing into the state from the federal government significantly exceeds the cash outflow from the state for care. This net positive cash flow pays for long term care infrastructure and to hire trained professionals to care for seniors. As these professionals tend to have above average pay the flow of these dollars into the economy probably results in SC currently paying very little for long term care for senior citizens. However, if the mix of federal v. state dollars changes that situation would come to an abrupt halt, placing the state in a difficult financial situation.

THE SECOND WAVE:

In addition, to the problems generated by the long term care needs of seniors, an influx of seniors has other secondary implication. As a state's senior population grows, the need for a significant pool of unskilled labor grows as well. Seniors, especially seniors with health problems, need assistance in a variety of areas, such as yard maintenance, house keeping, shopping, driving, and sitter services. These jobs typically will be filled by low cost unskilled labor. Further, in states like South Carolina where tourism is also a big part of the economy, an even greater need for low cost unskilled labor arises. These people work in the hotels, golf courses, and in restaurants.

As most of us are aware, America's southern boarder is currently under assault. The government anticipates between three to five million illegal aliens will enter this country next year from Mexico. These people will gravitate to areas where there is a need for low cost unskilled labor. The confluence of a large number of seniors and a large tourism industry makes SC ripe for a massive in-migration of illegal aliens seeking to perform these services.

An in-migration of illegal aliens is very dangerous for any state. Arizona, Texas, California and New Mexico are already suffering the effects of such an in-migration. Illegal aliens are the exact opposite of wealthy seniors. They pay no property or income tax. Their presence does not add to the value of property in the state. Their presence decreases the availability of jobs for American citizens and depresses wage growth among tax paying citizens. To top this off have no insurance and are incapable of paying for medical care and are heavy users of government services, such as roads, schools, free clinics, and emergency rooms without participating in the cost of their operation.

Finally, as we have no formal method of paying for the cost of medical care for illegal aliens the state bears a disproportionate share of that cost, placing upward pressure on the cost of care for everyone else, as well as taxes on legal residents.

In closing, SC needs to take a number of steps to assure an in-migration of seniors will benefit both the people desiring to move here and the people who currently live here, including.

1. Assuring resources are available to promote senior health.
2. Assuring resources are available to assist seniors in accomplishing tasks that in the past would have been provided by family members.
3. Fighting any reduction in the medicaid benefits available for long term care, especially any reduction in the percentage paid by the federal government.
4. Implementing policies to discourage the migration of illegal aliens to South Carolina.

Community Forums Report

(B)
In-Migration

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

IN-MIGRATION

LOCATION OF EVENT: City Council Chamber – Rock Hill, SC

Priority Issue:
The need to identify ways to deal with the growth of in-migration in the Catawba region.

Barriers:
1) Concerned by the growth of the northern part of Lancaster County in the Indian land. This is a very high growth area. This community is unprepared for the services that will be needed for the population growth there.
2) Certificate of need for acute care facilities not available.

Proposed Solution(s):
1) In-migration within the state primarily and not out of state folks in SC.
2) In-migration can be a positive thing for area where higher income residents move in. Often spouses die and the remaining spouse relocate where they originally came from.

SOUTH CAROLINA
WHITE HOUSE CONFERENCE ON AGING

April 25-27, 2005

(C)
Planning for the Future

Issue Papers

Springs F-H

Planning for the Future

By

Paul Franklin, MBA, CFP, RFG
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SC Aging In Place Coalition
Charleston, South Carolina

Planning for the Future---Panelist

Outline for SC-WHCOA Issue Paper----Paul Franklin

Statement of Issue:

South Carolina's older adults prefer to age-in-place in the comfort and safety of their residences but are unprepared to do so due to lack of knowledge, resources and homes that need repairing or modified to accommodate their changing circumstances.

Barriers:

1). Lack of available published information and knowledgeable personnel to provide aging-in-place training and counseling to older citizens.
2). Funding is needed to repair and modify homes.
3). Current Medicaid funding is biased toward nursing home care with limited resources available for home care and other community based services.
4). Older citizens lack knowledge about current government and private programs.
5). Government agencies, non-profit organizations and private service providers function in separate silos with competing agendas and outcomes.

Workable Solution(s):

1). Encourage government agencies, service clubs, non-profits, private sector and faith based organizations to participate in an aging-in-place education consortium for older adults.
2). Provide community based education programs and resources to neighborhood organizations promoting existing government and private aging-in-place programs
3). Develop a community directory of aging-in-place resources and programs.
4). Encourage the gerontology departments of our major universities to work with the public and private service providers to develop aging-in-place educational materials and workshops.

Recommendations:

Public and private programs and resources should be made available to help older adults to remain at home—independently, comfortably and safely. These programs and resources are not well known among the older population. A coordinated outreach program should be developed between public and private sectors to inform older citizens about these programs and services so more of our citizens can age-in-place.

Outcomes:

Once implemented the benefits would be as follows:

1). Older adults could remain in their current residences ---independently, safely and comfortably, and avoid or postpone institutionalized care.
2). Older adults would benefit from increased home values once repairs and modifications are made.
3). Utilization of an estimated $1.1 Billion from public and private funds may be available to help older adults pay for in-home services and to repair their homes.
4). Cost savings for Medicaid in South Carolina gained by shifting funding to home and community based services could exceed $50 million by 2008.

Paul Franklin is the President of the South Carolina Aging-In-Place Coalition, a non-profit organization dedicated to helping seniors stay independent and Age-In-Place at home for as long as possible.

Paul is also owner of Franklin Funding, Inc., a Federal Housing Administration insured lender of reverse mortgages. The firm is based in Charleston with offices in Columbia and Greenville, South Carolina. In addition to speaking actively to civic, community and professional groups, Paul has been assisting attorneys, financial planners, families, and individuals since 1995.

Paul received a BS Degree from Louisiana Tech in 1964 and an MBA Degree from Louisiana State University in 1965. He is a Registered Financial Gerontologist™, a Certified Financial Planner™ Certificant and a member of the American Institute of Financial Gerontology and the South Carolina Financial Planning Association.

He is a member of the Board of Directors of the National Reverse Mortgage Lenders Association headquartered in Washington, DC and serves on the Legislative Committee and chairs the Education Committee. Paul also serves on the Advisory Council of Financial Freedom Senior Funding Corporation, a subsidiary of Indy Mac Bank of Los Angeles and is Secretary/Treasurer of the Mortgage Lenders Association of Greater Charleston.

Paul is a member of the Board of Directors of the Berkeley-Charleston-Dorchester Regional Development Corporation and serves on the Trident United Way's Supporting Older Peoples Vision Council. He is a past Chairman of the Board of Goodwill Industries of Lower South Carolina, President-Elect of the North Charleston Breakfast Rotary Club, and a past member of the Charleston Trident Workforce Investment Board and Charleston Southern University Board of Visitors.

(Paul Franklin may be reached in Charleston, SC at 843-762-2218 or 800-375-0351)

Private Accounts in Social Security will Undermine the Program

By

Jane Wiley
State Director
AARP South Carolina
Columbia, South Carolina

Issue Statement: Private accounts in Social Security will undermine the program.

First, economic security for older Americans and their families requires strengthening Social Security. For 70 years, it has never failed to deliver important benefits to older Americans, people with disabilities, widow(er)s and other survivors. For over half of all beneficiaries, Social Security provides more than half their annual income.

Social Security is not in danger of going broke. The Social Security actuaries report that the system will be able to pay full benefits through 2042. The non-partisan Congressional Budget Office estimates the date is closer to 2052.

But it is certainly true that the program needs changes so that it will always be able to pay full benefits for all generations of Americans—today and tomorrow. These changes don't have to be drastic—two good examples are raising the wage base for FICA and diversifying Trust Fund investments—but the longer we wait, the more difficult and painful the steps we will have to take.

The nation needs an open dialogue on ways to assure long-term Social Security solvency. AARP has been holding forums on this around the country to ensure this dialogue..

One proposal that does not make good sense—and would worsen the solvency outlook rather than improve it—is to take money from Social Security taxes for private investment accounts. This would divert payments going into the system that are needed to pay Social Security. Estimates are that a 2% private account carve-out would create a shortfall of over a trillion dollars. That amount eventually would have to be covered by raising taxes, cutting benefits, and/or taking on new debt.

In addition, private accounts introduce risk into essential retirement security. Stock and bond markets rise and fall; inevitably, there will be winners and losers. The essence of Social Security is that it assures a predictable measure of retirement income. Private accounts in Social Security threaten that assurance.

We need private savings, and AARP has long championed improvements in private vehicles like 401(k) plans and IRAs. But we need these savings <u>in addition</u> to Social Security, not at the program's expense.

The buzz phrase being bandied about by those who favor privatization is "an ownership society." They favor taking a portion of Social Security taxes and diverting it to individuals to invest. They say such a system would give workers ownership of their money. It would allow taxpayers to put their own dollars into stocks, bonds, and other investments that would pay them a higher return.

Those who oppose privatization, including AARP, argue that setting up private accounts would effectively scuttle Social Security. In fact, siphoning money from Social Security will not strengthen it; it will just make the problem much worse.

First, the transition costs alone would be crushing --as high as $2-$3 trillion, according to AARP's own economic analysis

Second, diverting a portion of Social Security money to private accounts means that there would be fewer dollars available to pay Social Security benefits. That would leave the whole system with less of a reserve, as well as less cash on hand to pay beneficiaries. This situation would lead to hard choices: cutting benefits, raising taxes, or doing none of the above and watching the trust fund run out of cash sooner.

According to a letter entitled "The Consequences of Social Security Privatization," signed by Congressmen Charles B. Rangel (D-NY) and the late Robert T. Matsui (D-CA), diverting a portion of workers' current Social Security contributions to private accounts "blows a hole in the Trust Funds and directly threatens our ability to pay current retirees." They predict that under privatization the trust fund reserves will be wiped out by 2021, a full 20 years sooner than if the system had been left alone.

Advocates of private accounts in Social Security state that these accounts will give individuals more control of their money. People already have control over their money when they invest in private pensions, IRAs, and 401(k) plans. When combined with the solid foundation that Social Security provides, these are excellent vehicles for retirement savings

Those who favor private accounts also believe that individuals can do better investing on their own than relying on the government to do it for them. The truth is, some people may do better. But who's going to pay for those workers who do worse?

Under privatization, current workers will have to pay three times. Once to ensure the benefits for those currently at or near retirement, once for themselves, and once more for those whose investments didn't pan out." In the current Social Security system, the risk is near zero. You know it will be there regardless of what the market does. That's because U.S. Treasury bonds don't crash when the stock market does.

So what can be done? Yes, the Social Security system needs some work, but there's nothing so seriously wrong with it that some due diligence and nonpartisan intervention and planning can't repair. There's no need to take the risky step of privatization.

Planning for the Future: Employer Based Pensions and Health Insurance—What are the Trends?

By

Helen I. Doerpinghaus, Ph.D.
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Planning for the Future:
Employer Based Pensions and Health Insurance – What are the Trends?

Helen I. Doerpinghaus, Ph.D.
Moore School of Business, University of South Carolina

Statement of the Issue:

Employees today repeatedly cite pensions and health insurance as the two most important benefits that they receive at work. One protects from insufficient income after retirement and the other protects against high medical expenses. In our aging society, where Social Security funding is in question and medical costs continue to rise, interest by government, business, and consumers in securing private pensions and health insurance is only likely to increase.

Identification of Barriers:

The trend today with both employer based pension and medical insurance is toward less employer liability and more employee choice. Employers want to limit their financial liability by promising only to make a fixed contribution regardless of what happens to the cost of retirement and health benefits. Increasingly plans today require employees to share more of the cost and make more of the design decisions that tailor retirement and medical benefits to best suit their personal needs.

Half of employer benefit dollars go to retirement. With the aging workforce, employers are looking for lower cost alternatives. In addition, the nature of careers has changed significantly as most employees no longer spend 30 years with one employer but have eight to ten jobs on average. Consequently, a pension plan that is fully portable and does not weight pension accrual toward later years of employment is needed for employees to fully appreciate an employer's investment in the company retirement plan. Plans also need to work well for the increasing number of organizations using part-time and leased workers. All of these factors affect the types of retirement plans that employers prefer today.

The trend today is away from defined benefit plans and toward defined contribution pensions. In 1996 about one third of workers were in defined benefit plans, and today about 20 percent are. Defined benefit (or DB) plans guarantee a set retirement benefit and the employer contribution fluctuates as needed to meet that target. Defined contribution (or DC) plans do just the opposite: the employer guarantees an annual contribution to the employee's retirement account and the amount available at retirement fluctuates due to factors such as investment return. With a defined benefit approach, the employer has more funding risk. With a defined contribution approach, the employee takes that risk. It isn't surprising that employers are drawn to DC plans.

Even within the DB plan universe the trend today is toward a new DB alternative, "Cash Balance Plans." Among DB plans the number of Cash Balance plans increased from four percent in 1996 to 23 percent by 2000. These are essentially hybrid plans that fix the employers contribution like a defined contribution plan does, but provide a guaranteed rate of return on the

account, relieving the employee of some investment risk. Cash Balance plans are popular because they limit employer funding liability but also because they are better suited for a mobile workforce where frequent "job-changers" value a fully portable pension.

Within the defined contribution pension area there is also increased interest in plans that maximize employee choice and personal responsibility. The 40l(k) has enjoyed tremendous popularity in the last decade, largely because it is a qualified DC plan which allows employees to fully fund the plan through their own salary deferral. The employee tailors contribution amounts and investment choices to meet individual retirement goals. The employer has the option of contributing or matching, but this is not required. With the fixed annual employer funding commitment, individual choice, and full portability for employees, the popularity of the 40l(k) is likely to continue.

This trend toward defined contribution retirement plans can be problematic for employees. Job changes allow early cashing out and many workers are taking retirement funds for consumption during their working years. This will significantly weaken the effectiveness of the private pension system in providing economic security for the elderly in years to come. Poor employee investment decisions also raise question about future benefit adequacy. Keeping up with the effects of inflation, both during the working years and after retirement, is critical. With DC plans this requires aggressive investment during the active working years, something that evidence to date suggests workers on the whole are not doing. Post-retirement inflation risk can be hedged through annuities, but annuity purchase is generally more costly for women in DC plans. This is an important issue for those with greatest longevity risk, women over 65, one-quarter of which are poor. Despite these drawbacks the trend toward DC arrangements is likely to remain strong.

Many of the phenomena we see with retirement also exist with group medical expense insurance plans. Employers continue to experience cost pressures, pushing them to explore alternatives which require employees to share the costs and make choices about their coverage. In the 1970's managed care was supposed to solve the cost problem, and there is no doubt that the move to HMOs, PPOs, and other forms of managed care, mitigated for a time the increase in premiums. Today more than 75 percent of the population is in some type of managed care plan. But that has simply not been enough.

The recent trend is toward consumer-driven health care. Two primary alternatives are available, one in which employers provide a defined or set premium contribution toward health insurance for employees, and employees pay the rest of the premium and select the coverage that they prefer (e.g., HMO, PPO, traditional indemnity coverage, etc). Another option is for employers to offer high-deductible insurance plans with savings accounts (HSAs) for each employee to use to meet out-of-pocket costs below the deductible. Employers may fund the savings account in part or leave that to employees.

Estimates are that about 40 percent of employers are offering HSAs to employees this year (2005). HSAs reduce health care cost by eliminating administrative and claim costs for

small losses (e.g. the first $2,000 of an individual's annual health care expenses) which can reduce total premium by as much as 80 percent. HSAs also reduce cost by providing financial incentives to employees to use only necessary care, since they retain the balance of the HSA if they don't need services. It is too early to see the effect of HSAs on cost or service delivery. There is concern that those with low income or high health risk will be poorly served by HSAs since meeting the high deductible can be difficult with income constraints and frequent users will not build an account balance.

Another trend we are seeing in the health care market is a reduction in the number of employers providing retiree health insurance. Retiree health insurance is important for those retiring before the age of Medicare eligibility or for those eligible for Medicare desiring a private supplemental policy to fill gaps in coverage. In 1993 approximately 45 percent of employers provided coverage to early retirees, but by 2004 only 25 percent did. During this period the percentage of employers providing Medigap coverage to retirees 65 years or over declined from about 40 to 20 percent. Other employer initiatives to cut retiree funding liability include providing less generous benefits, requiring retirees to share more of the premium, adopting a defined contribution approach to retiree coverage, or moving retires into managed care plans. Rising costs and accounting rules have driven this trend. This trend, together with the precarious financial condition of the Medicare program, suggests that retiree health insurance needs warrant serious study and public policy attention.

Proposed Solutions and Recommendations to the Conference:

In sum, with pension and health care benefits today the trend is toward reduced employer liability and increased employee cost sharing and decision-making. In the public retirement sector the same trend is surfacing as we discuss privatization of Social Security. In this new environment individuals will need to be able to understand health plan choices and investment options and determine what is best for their own situation. In this new setting economic literacy is required, something that was far less crucial when employers made all plan design choices and took more of the funding risk. Education for economic literacy needs to begin in grades K – 12 and needs to be widely available to adults taking on this responsibility in mid-life as well. Simply providing information about medical expense plans and investment risk-return trade-offs is not enough if people do not know how to apply or use the information for their own financial planning.

The trend toward individual responsibility in employer-based pensions and health insurance is strong, and likely to continue. There is a need for all of the stakeholders – employers, employees, public policymakers, educators, and financial institutions -- to work together to make the new approach successful.

Financial Exploitation of the Elderly

By

Randy Thomas, MA
Retired Detective
Heisler and Associates
Blythewood, South Carolina

Financial Exploitation of the Elderly

Randy Thomas

An elderly Hilton Head couple are bilked out of as much as $20 million…by a caregiver. (The State, Aug 29, 2004)

The Issue

This story is but one of many that takes place in South Carolina every day. While the amount of money is significant it is typical of the dynamics of elder financial exploitation. The extent of this problem lacks data but some studies have estimated that elders in the United States may experience a financial loss as much as $1.2 to $4 billion a year. A number of studies have found that this is a significant problem for the elderly and is vastly under reported. Studies have also shown that this, along with other forms of abuse and neglect, lead to an earlier death. While many of our elderly in South Carolina do not possess the wealth of the Hilton Head couple they are still being exploited with a relative economic loss just as significant as the couple in the story.

Much publicity has been generated by such organizations as AARP regarding the financial exploitation of the elderly. This attention has focused on such crimes as telemarketing schemes, ID theft, home repair scams and other forms of fraud that specifically target the elderly. This is no doubt that these occur and the economic loss to the victim is significant. However, the majority of exploitation is not done by strangers at the end of the phone but by trusted family members and caregivers. It is done through the misuse of Powers of Attorney, guardianships, credit card use, theft from checking accounts and undue influence. These family members often promise to provide care when it is most needed. Very often the victim is initially unaware of the loss and then when discovered is too embarrassed to report it and does not want to see a son or daughter go to jail.

Barriers

The problems associated with this issue occur at every level; national, state and local. Specifically they are:

- Lack of public and professional awareness of the problem of financial exploitation.
- Lack of adequate Federal recognition of the problem.
- Lack of reporting and, when reported, adequate response by the criminal justice system.
- Lack of professional expertise by professionals tasked to assist the elderly to include the criminal justice system.
- Lack of adequate training for professionals, particularly criminal justice, in the most effective way to address the problem.

Solutions

South Carolina has adequate statutory provisions for addressing financial exploitation (Title 43, Omnibus Adult Protection Act). The problem has been the lack of effort to protect the victims and hold offenders accountable at every level. This is particularly true for the criminal justice system. The solution is to increase the criminal justice and social service systems ability to recognize and address the problem of financial exploitation. At the Federal level the United States Senate has held a series of hearings on this issue however little concrete action has taken place to address systemic changes that would address the problem. Legislation has been introduced in Congress (The Elder Justice Act) to provide focus and resources but has not yet been passed. However little has been done at the state level to focus on this problem.

Recommendations for Action

Therefore it recommended that the following actions take place:

- Increase public awareness of the problem through the media.
- Passage of the The Elder Justice Act (S.333).
- Provide resources to improve the professional expertise of those who are responsible for protecting victims and holding offenders accountable.
- Promote aggressive criminal justice responses to incidents of financial exploitation.
- Provide the elderly with resources to structure their legal affairs in such a manner as to enhance protection of their assets.

Planning for the Future

By

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Extension Family Resource Management Specialist
Clemson University
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Planning for the Future

Issue/Problem

Many South Carolinians are in great danger of not being financially stable and secure throughout their lifetimes. Because most people did not receive formal financial education in their youth, they need lifelong learning opportunities to help them improve their financial management skills. Increasing financial literacy throughout the life cycle is essential to avoid the following threats to financial security.

- Expansion of credit availability has resulted in record levels of indebtedness. The average credit card debt for households with credit card debt hovers around $8,000. This is very alarming since many households do not have any credit card debt. It is estimated that those who do have credit card debt is closer to $12,000.[5]
- There were over 1.62 million bankruptcy filings in 2003. Almost 98% of these were filed by consumers. In SC there were 16,212 bankruptcy filings in 2003.[3] Senior citizens are the fastest-growing group of debtors in the US; bankruptcy filings among seniors has jumped 244% from 1991-2002.[8]
- The personal savings rate has continued to be at very low levels over the last decade.[6]
- Many people have refinanced their mortgages and spent down the equity in their homes. The average equity is just 56%.[5]
- The cost of health care and long-term care continues to increase at rapid rates.[6]
- Of the 78 million Baby Boomers (born between 1946 and 1964) in 2000, one fifth were financially at risk earning less than $30,000/ year with $18,149 the average yearly wage. Seventy percent planned to work in their retirement years and 33% feared growing old.[2]
- Concerns abound over the ability of individuals to adequately put money aside to meet short-term financial obligations and to accomplish long-term goals (i.e., financing children's education, providing for a secure retirement, assuring good health, building an estate).[6]
- Changes in pension funding mechanisms have led to the conclusion of the "Retirement Planning in the 21st Century" retirement think tank sponsored by the National Endowment for Financial Education (NEFE®) in 1999, "Responsibility for retirement security in the 21st century will fall squarely on the shoulders of individual Americans. This underscores the need to save significantly more than what people currently are setting aside for their retirement."[6]

The financial marketplace is very complex. Consumer decision making is made more difficult for the following reasons.

- There are limitless decisions to be made about a wide range of products, services, and providers.[1]
- There are low levels of financial literacy when the knowledge needed to successfully manage personal finances has increased exponentially.[6]
- Persons age 65 and older, non-Hispanic blacks, and Hispanics were less likely than all persons to have experience with financial products and basic money management skills.[4]
- Approximately 4.4 million households age 50 and older try to manage their money without a checking account; they are "unbanked."[1]

Fiscal Impact

Low levels of financial literacy affect the quality of life of individual households, reduce wealth generation, and limit the attainment of goals such as buying a home, funding higher education, starting a business, and securing a comfortable retirement. "When taken in the aggregate [this] has important macroeconomic implications, as a more financially educated population contributes to market efficiency and thereby helps promote the general economic welfare."[7]

Solutions

One very viable, long-term solution for South Carolinians is to pass and fund **H. 3020,** a bill designed "To amend the code of laws of South Carolina…to enact the Financial Literacy Instruction Act of 2004, to provide for the development or adoption of a curriculum for local school boards to teach financial literacy, and to provide for the establishment of a fund to receive public and private contributions for financial literacy instruction….The State Board of Education shall develop or adopt curricula, materials, and guidelines for local school boards to use in implementing a program of instruction on financial literacy within courses currently offered in high schools in this State."

Recommendations

AARP[1] and many financial educators support the following recommendations regarding financial literacy:

- Federal and state financial literacy initiatives should focus increased attention on the financial literacy needs of Baby Boomers and the older population.
- States should establish interagency councils to coordinate existing and future efforts to increase financial literacy. Councils should include financial service providers, consumer groups and representatives, researchers and educators (such as Cooperative Extension), and government agencies, especially those that serve older persons.
- Federal and state policymakers should require alternative financial service providers to eliminate abusive, unfair, and deceptive practices.

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Community Forums Report

(C)
Planning for the Future

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

PLANNING FOR THE FUTURE

LOCATION OF EVENT: Florence Civic Center – Florence, SC

Priority Issues:

D) With limited resources in government, there is a need to emphasize planning for individual responsibility.
E) Save for an adequate retirement
F) Employer based pensions and health insurance
G) Long term care insurance
H) Prevention of financial fraud, abuse, and exploitation
I) Reverse Mortgages

Proposed Solution(s):

C) As stated in the Older Americans Act, it is our responsibility to assist older people in this country in exercising freedom, independence, and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community-based services, and program provided for their benefit. This includes providing seniors with the information they need to make informed decisions about their retirement.
D) Prevent the conversion of defined benefit plans to cash balance plans, which violate federal laws governing age discrimination.
E) Strengthen private pension systems by implementing shorter vesting periods, improved coverage standards, and better disclosure requirements to increase the number of persons receiving pensions and the average pension amount.
F) Expanding the availability of and use of self-directed services that enable consumers to coordinate and manage their retirement, especially w here technology can enhance benefits, services, and independence in more cost-effective ways.
G) Increase awareness about Reverse Mortgages and fund agencies to provide assistance with applications.

LOCATION OF EVENT: Gaillard Municipal Auditorium – Charleston, SC

Priority Issue:

Older adults ca no longer be totally dependent on Social Security and retirement pensions due to their prolonged length of years in retirement (averaging 25-30 years). Financial planning for retirement is no longer required by businesses and corporations, as this responsibility has been directed to the individual.

Barriers:

1) Borrowing from Social Security to support other programs (i.e., the war in Iraq).
2) Not enough money in the Social Security Fund to support retirees for the future.
3) Lack of education in financial planning.
4) Lack of awareness that Social Security is an insurance and pension program.

Proposed Solution:

1) Emphasis on education for all young adults by school, financial institutions, and employers.
2) Education on long term care financial planning.
3) Education on debt management.
4) Explore flexible pre-tax benefits for retirees.
5) Explore adjustments to stabilize Social Security.

Recommendation:

Social Security should be restored to its financial long term health before any changes are made.

LOCATION OF EVENT: Capital Senior Center – Columbia, SC

Priority Issue:

Need for stiffer penalties and reporting requirements for financial exploitation, abuse and neglect; lack of planning by baby boomers; solvency of long term care insurance companies; businesses only keep benefits that benefit t hem; need for match program for long term care insurance; tax dollars need to go to seniors instead of education; transportation problems cause isolation; need for senior driving advocate.

Barriers:

1) Lack of services for no cost or small costs.
2) Corporate America's lack of providing pensions and health insurance.
3) Lack of portability of retirement – need for retirement programs such as Teachers Insurance and Annuity Association – College Recruitment Equities Fund (TIAA-CREF).
4) Need to be federal programs of retirement – guaranteed that any corporate company of certain size has to offer.
5) Social Security has benefit for spouses – other retirement plans need the same.
6) There is a waiting list for transportation for the disabled.

Proposed Solution(s):

Law Enforcement and other protocols that do not change from state to state in regard to financial fraud, abuse and exploitation. Federal guidelines and repercussions such as Korea's law to take estate if financial neglect or exploitation occurs with family.

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
Rising health care costs; funds for retirement planning education, financial planning; job market – more dependable older workers; education in the job market; insurance – what are options for seniors, insurance education, managing financial records, choices – value of insurance; quality of life – home based services; planning for senior savings; fear of giving out personal information; transportation; mental health.

Barriers:
Funding; maintaining the workforce; limits on insurance coverage; education.

Proposed Solution(s):
1) Better education, volunteerism.
2) Better organize seniors to voice issues.
3) Overcome stigma associated with aging.

LOCATION OF EVENT: H. Odell Weeks Activity Center – Aiken, SC

Priority Issue:
Prevention of financial fraud, abuse, exploitation, and telephone scams.

Barriers:
1) Need more education and awareness "Watch Dog" programs to have neighbors helping neighbors in the prevention of fraud and abuse.
2) Lack of Public Guardianship programs to provide for the needs of seniors who have no involved family members.
3) Isolation and loneliness of seniors.
4) Older people are vulnerable to identity theft, telephone fraud, and exploitation.

Proposed Solution(s):
1) Involve the faith-based communities to assist members of their own congregations.
2) Develop a public guardianship program for adults in the State of South Carolina.
3) Address telephone scams and other scams that seem to prey on seniors.
4) Involve law enforcement in training older adults to be able to identify scams and the people who are attempting to scam or exploit them.

LOCATION OF EVENT: Orangeburg County Council on Aging-Orangeburg, SC

Priority Issue:
Prevention of financial fraud, abuse, exploitation, and telephone scams.

Barriers:

1) Need more education and awareness "Watch Dog" programs to have neighbors helping neighbors in the prevention of fraud and abuse.
2) Lack of Public Guardianship programs to provide for the needs of seniors who have no involved family members.
3) Isolation and loneliness of seniors.

Proposed Solution(s):

1) Involve the faith-based communities to assist members of their own congregations.
2) Develop a public guardianship program for adults in the State of South Carolina.
3) Address telephone scams and other scams that seem to prey on seniors.

SOUTH CAROLINA
WHITE HOUSE CONFERENCE ON AGING

April 25-27, 2005

(D)
Workforce Issues

Issue Papers

Atlantic B

Workforce Issues

By

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SOUTH CAROLINA – WHCoA ISSUE PAPER
Submitted by Billy Wooten, Regional Director Experience Works, Inc.

Statement of the issue as addressed in the paper

It is an exciting time for the aging workforce. Demographic realities are on the side of older workers in South Carolina and across the country: 78 million members of the baby boom generation are now more than 40 years of age. Innovative approaches to employment and training are on the horizon and the Workforce Three R's – Recruitment, Retraining, and Retention, are in for some big changes. Now is the time to embrace policies that are successful and develop new strategies that value and promote the skills and abilities of aging workers of our state and country.

Barriers to be overcome in order to act on the issue

The barriers that older workers, workforce development professionals, aging advocates and the business community must address and overcome include, but are not limited to:

- Age discrimination and unsubstantiated myths of older workers
- Workplace disincentives to remaining employed and the concept of retirement as a required rite of passage
- Physical, psychosocial, societal, organizational, and economic realities of an aging workforce that must be researched and addressed through policies, accommodations, and cultural changes
- Life long learning, retraining, and multiple career path accommodations that are tailored to meet the needs of older individuals
- The challenges of low skilled, low income, older workers with multiple barriers to employment, who must work to maintain the basic essentials of life including food, shelter, clothing, and medical care.

Workable solution(s) to overcome these barriers

Age Discrimination and Unsubstantiated Myths About Older Workers

Age discrimination is real. More than 17,800 age discrimination complaints were filed in 2004 with the U.S. Equal Employment Opportunity Commission, which is the third highest number of complaints in the past decade. Coupled with the myths about older workers being less dependable, more accident prone, harder to train, and not wanting to work, older workers are not willing to be subject to unfair treatment that stands in their way of employment. The continued pressure to challenge and interpret existing laws in the state and federal courts will increase the effectiveness of these laws and point to gaps that must still be addressed. The role of older worker advocates is to develop policy proposals and messages that result in legislative and regulatory improvements that increase the fair treatment of older individuals in the workplace.

Workplace Disincentives to Remaining Employed and the Concept of Retirement as a Required Rite of Passage

Until just recently early retirement packages were a prevalent way for companies to hire younger workers, reduce costs, and thin the ranks of their aging workforce anxious to leave out of boredom, lack of challenges and upgraded training, or crushed hopes for further advancement. With fewer younger workers available, many companies are rethinking "early retirement." In the short term, creative but economically feasible alternative work arrangements, phased retirement, and flexible work options need to be developed and adopted so experienced staff can continue working at their present jobs if they so desire. In the longer term, new messages must be developed to promote the value of work to older people, the economic and organizational contributions older workers can make to their employers, and the advantages to both employers and employees when retirement is not an inevitable outcome of advancing years.

Physical, Psychosocial, Societal, Organizational, and Economic Realities of an Aging Workforce That Must be Researched and Addressed Through Policies, Accommodations, and Cultural Changes

Medical advances, technology, job functions, and attitudes about older workers have dramatically changed over the last 50 years. Research is needed to study older workers needs of the 21st century and recommend policies, accommodations and systems changes. While some research is needed on the national level, state and local educational institutions, business organizations, economic and workforce development entities, and professional, trade, service, and civic groups can provide valuable input into how employers and employees perceive the future of older workers, their needs, and possible solutions.

Life Long Learning, Retraining, and Multiple Career Path Accommodations That are Tailored to Meet the Needs of Older Individuals

A recent study conducted by Dr. Tracey Rizzuto, assistant professor of psychology at Louisiana State University, found that older workers exhibited more willingness to learn new technology and concluded that training and retraining is a small price to pay to retain a valuable segment of the workforce.
Whether older workers want to remain in their present jobs, want career advancement or a whole new vocation, they will need constant training to do their jobs effectively. Consequently, cost effective and industry developed training, which takes into consideration older individual learning styles, applicability, life experience, and desire to move quickly from training to job performance is needed to accommodate employer and employee interests.

The Challenges of Low Skilled, Low Income, Older Workers With Multiple Barriers to Employment

While many aging workers have been successful in their chosen career, others have struggled their entire lives. Many of South Carolina's older adults live in rural areas where there are few jobs, limited options for training, and scarce transportation. Adding low skills, no GED, disabilities, or homelessness, these older workers are at a severe disadvantage when competing for jobs. Current programs such as the Senior Community Service Employment Program and Workforce Investment Act Programs provide some assistance, but as the workforce ages, significantly greater resources and solutions are needed to ensure that these older workers have the skills needed by employers and they will get hired. Expanding employer partnerships that value the opportunity to train individuals on specific tasks, encouraging the use of technology for work from remote locations, and providing economic development incentives for creative approaches to employing older workers with multiple challenges will provide long-term economic and social benefits.

Recommendations for Action

☑ Educate the business community on the value of older workers, their ability to learn and adapt, and the costs of age discrimination. Market the ability of seniors to learn and adapt to new technology and provide benefits to the company.

☑ Strengthen coalitions of legal, legislative, governmental, educational, private sector, and community and faith-based organizations that examine community needs and offer concrete solutions to aging workforce issues.

☑ Encourage public and private research that identify employer and employee needs and interests, develop new training methodologies, and offer concrete solutions to the economic and societal implications of an aging workforce.

☑ Implement the recommendations of the USDOL Office of Policy Development and Research Protocol for Serving Older Workers, which calls for innovative strategies for serving older workers and increased training of Workforce Investment Act One Stop/Career Center staff on issues and barriers that older workers face and debunk the common myths held about older workers.

☑ Significantly increase funding and expand services of the Senior Community Service Employment Program, Title V of the Older Americans Act . The funding formula for this program has not been revised in more than 20 years, yet the need has dramatically expanded. In its 40th year of service to disadvantaged older workers, community based organizations, the workforce system and the business community, SCSEP provides a strong leadership role in serving older workers and their employers in South Carolina and nationwide and can serve as a model for innovative targeted services for the future.

Workforce Issues

By

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The Impact of Long Term Care on Our Workforce

By Joe Riley III, CLTC, (Certified in Long Term Care)
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The aging process and caring for the aging is impacting business nationally and, more importantly, in South Carolina. A large portion of caregivers (currently about 44 million people in the U.S.) already work full time but have the responsibility of caring for family members who do not have money for a professional caregiver.

Here are some key points depicting why LTC is problem for employees in the workforce:

- 51.8% of informal care providers are employed full-time[1]
- Caregivers spend approximately $2 billion in out of pocket expenses for caregiving[1]
- The estimated cost of informally provided long term care to American business is in excess of $29 billion a year![1]
- 35% of both men and women workers say they have provided regular care for a parent or in-law over age 65 in the past few years, helping them do things that they could not do themselves[2]
- By the end of this decade, the number of employee caregivers is expected to increase between 11 and 15.6 million, or 1 in 10 employees[3]

CAREGIVERS IN THE WORKPLACE

In one important study of working caregivers, those surveyed said they made at least one formal adjustment to their work schedule as a result of caring for a partner or other family member.[4]

16% - Quit their job

20% - Cut back to part time

22% - Took a leave of absence They also stated that caregiving affected their ability to advance on the job.

29% - Passed up a promotion, training, or assignment

25% - Passed up an opportunity for a job transfer

22% - Were unable to acquire new job skills

We in the Palmetto State are obviously experiencing a new crisis of eldercare and its impact on workplace productivity. The employer loses twice-once when the employee leaves work, and then again when the employee returns exhausted physically, emotionally, and financially from caring for their family member.

Families today are smaller and more geographically dispersed, and far more women-traditionally the family caregivers-are juggling work and childrearing along with their caregiving duties. Forty percent of caregivers are raising their own children, and two thirds are working, mostly full-time.[6] This is an example of what many people refer to as the “sandwich generation”.

HOW IMPORTANT IS LTC TO EMPLOYEES?

Over 98% of employees who purchase LTC insurance through their employers, or are provided coverage, say policies give them peace of mind.[5] Their most important reasons for buying LTC insurance are:

- Protect Assets
- Leave an Estate
- Preserve Financial Independence
- Guarantee Affordability of Coverage in later years

It is evident that the federal government has shifted the responsibility of LTC and LTC insurance to the backs of Americans. This is why the the Federal LTC Plan was set up in 2001 (a partnership between MetLife and John Hancock). The federal government also understands that Medicaid could overwhelm the states if something is not done quickly. This led to the current involvement of the National Awareness Campaign by the Governor's Association to do a broadcast mailing to citizens in their respective states. This program targets 50 to 70 year olds in the states of Arkansas, Idaho, Nevada, New Jersey, and Virginia.

The bottom line is that there needs to be more awareness about LTC and its impact on the productivity of our workplaces in America and, more importantly, in the Palmetto State. Also, there needs to be more incentives to make LTC insurance more affordable to employers to provide this benefit to their employees. The following recommendations are national in scope but should add insight to incentives to make LTC insurance more viable as an employee benefit.

RECOMMENDATIONS:

1. To support our SC Congressional Delegation to get behind S.602 "The Ronald Reagan Alzheimer's Breakthrough Act of 2005." Major measures of this bill would include:

Encourage families to prepare for their long term care needs by providing an above-the-line tax deduction for the purchase of LTCi

Increase funding for the National Family Caregiver Support Program to $250 million

Establish a $3000 tax credit for caregivers to help with the high health costs of caring for a loved one at home

1 To support our SC Congressional Delegation to get behind the LTC Retirement and Security Act that would permit inclusion of LTCi in cafeteria plans (section 125 plans).

2 To support our SC Congressional Delegation to get behind efforts to make LTCi premiums 100 percent deductible to employers regardless of their incidence of ownership.

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Labor Force and Government Finance Impacts of South Carolina's Aging Population

By

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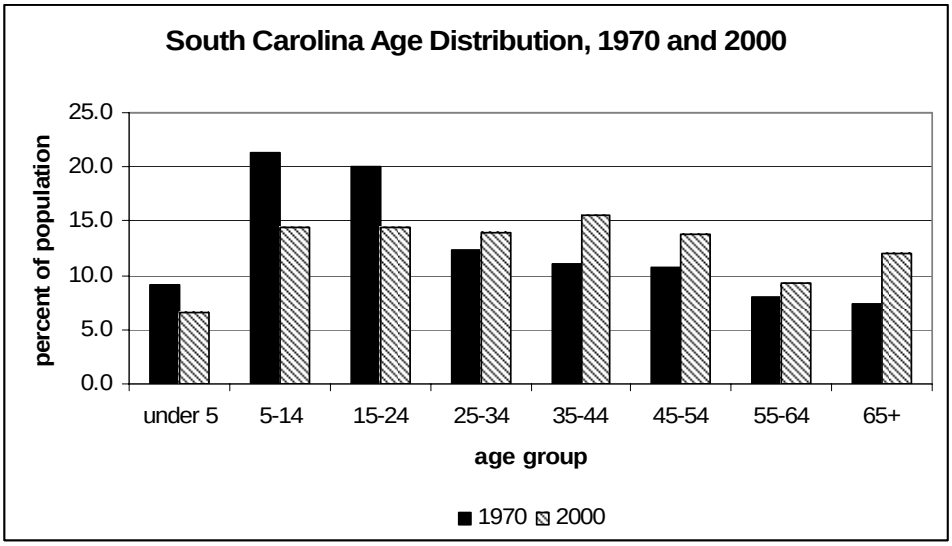
Labor Force and Government Finance Impacts of South Carolina's Aging Population

Dr. Donald L. Schunk, Moore School of Business, University of South Carolina

South Carolina has consistently seen its population grow slightly faster than the national average in recent decades. Between 1980 and 1990, the state's population grew a total of 11.7 percent compared to 9.8 percent nationally. Between 1990 and 2000, South Carolina's population grew 15.1 percent while the nation's population grew by 13.1 percent. This trend appears to be continuing into the earliest years of the 21st century. Between the 2000 Census and 2004, South Carolina has seen population growth of 4.6 percent while the U.S. has grown by 4.3 percent.

These are long-term trends that are likely to persist as the U.S. population continues to move towards the South and West from the North and East. Since 1790, the mean center of the U.S. population has moved roughly 1,000 miles to the West and South from Chestertown, Maryland in 1790 to Edgar Springs, Missouri as of 2000.[2]

South Carolina's population is not only growing relatively quickly, but it is also aging relatively quickly. In 1970, for example, 50.5 percent of the state's population was less than 25 years old. By 2000, the share of residents in this age range had fallen to 35.3 percent. Meanwhile, the share of the population aged 55 years and older has risen from 15.4 percent in 1970 to 21.4 percent in 2000. Between 1990 and 2000, the number of people aged 15 to 34 in South Carolina actually fell from about 1.15 million to less than 1.14 million. The changing age distribution is illustrated below.



This aging of the population will have substantial labor force and government finance impacts in the coming years and decades. For the U.S., according to the Bureau of Labor Statistics the percentage of the labor force aged 45 and older stood at 33 percent in 1998. It is

[2] The U.S. Census Bureau issues the location of the mean center of the U.S. population after each decennial census. Between 1990 and 2000, the mean center of the population moved more than 12 miles south and more than 35 miles west.

estimated that by 2008, about 40 percent of the labor force will be 45 or older. Meanwhile, the percentage of the labor force between the ages of 25 and 44 is expected to fall from 51 percent in 1998 to 44 percent by 2008. Overall, the median age of the workforce should climb from 38.7 years in 1998 to 40.7 years by 2008.[3]

On a more detailed level, the wave of retiring baby boomers is expected to have the largest impacts on those industries and occupations that are generally less subject to productivity-enhancing gains in technology. For example, occupations such as education and health care tend to see lower gains in productivity. Therefore, large losses from retirement will directly impact the provision of education and health services unless new workers enter these fields. However, even in occupations that do see more productivity advances, such as manufacturing, there can be steep learning curves such that the loss of human capital and institutional knowledge will be felt.

The following table provides estimates of the national retiree replacement needs for certain occupations. Here, the majority of the occupations facing the greatest replacement needs are service-related fields, many of them in education as well as health care and government.

Occupations with Greatest Retiree Replacement Needs, 1998-2008

Occupation	Retiree replacement needs (thousands)
Secretaries	519
Truck drivers, heavy	425
Teachers, elementary school	418
Janitors and cleaners	408
Teachers, secondary school	378
Registered nurses	331
Bookkeepers, accounting and audit clerks	330
Teachers, college and university	195
Administrators, education and related fields	178
Farmers	175
Supervisors, construction occupations	165
Administrators and officials, public administration	143
Real estate sales occupations	144
Insurance sales occupations	135
Industrial machinery repairers	125
Maids and housekeeping cleaners	122
Private household cleaners	112
Physicians	108
Financial managers	102
Lawyers	99

source: Dohm, Arlene, "Gauging the labor force effects of retiring baby-boomers."

[3] Dohm, Arlene, "Gauging the labor force effects of retiring baby-boomers," *Monthly Labor Review*, July 2000, pp. 17-25.

From the perspective of government revenue generation, this aging of the population is likely to squeeze state and local governments. The aging population may result in downward pressure on income and sales tax revenues, and a growing share of the population will be eligible for tax breaks offered to seniors. The aging population is also likely to exert upward pressure on government service provision.

[1] The U.S. Census Bureau issues the location of the mean center of the U.S. population after each decennial census. Between 1990 and 2000, the mean center of the population moved more than 12 miles south and more than 35 miles west.

[1] Dohm, Arlene, "Gauging the labor force effects of retiring baby-boomers," *Monthly Labor Review*, July 2000, pp. 17-25.

Health Care Worforce Shortages

By

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SC White House Conference on Aging Issue Paper

Health Care Workforce Shortages
Renatta S. Loquist, RN, MN, FAAN

I. Statement of Issue:

Numerous state and national studies have predicted an unprecedented shortage of nurses and allied health personnel over the next decade. These shortages are a result of

1. an aging nursing workforce who will retire from practice or at a minimum reduce the number of hours they spend in practice;
2. a decline in the number of female high school graduates choosing nursing as a career and the difficulty in recruiting men and minorities into the profession;
3. long waiting lists in schools of nursing due to a lack of sufficient qualified faculty to increase enrollments and graduate more students;
4. lack of adequate funding of educational programs to expand capacity to meet the demand for graduates;
5. lack of incentives to entice nurses and health personnel to practice in rural and other settings where high shortages exist.

The Bureau of Health Professions, Health Resources and Services Administration (HRSA) has predicted a shortfall of 1 million nurses by the year 2020, meeting only 36% of the estimated demand for nursing services in that period. The same study predicts that SC will have a shortfall of 12,100 nurses, meeting only 32% of the demand for services. Given these data, SC would need to, at a minimum, double graduation rates from every program in our state to keep pace with the deficit. At the current budget levels, every nursing education program is operating at full capacity and cannot increase enrollment.

The growing shortage of nurses and other health care providers along with the increasing demand for services generated by the baby boomers reaching age 65 and becoming Medicare-eligible along with the increasing population over age 85 has been described by some as the "perfect storm" scenario. The age 65 population is expected to grow by 72% by 2020 (HRSA). As SC continues to entice seniors to our state as a desirable retirement location, our health care organizations and agencies will continue to be stressed by growing demand for services.

The insufficient numbers of nurses impacts the ability of hospitals and long-term care agencies to admit patients, results in delays for services, closed units, loss of income to communities and health care facilities, and ultimately an impact on the morbidity and mortality of our population.

II. Barriers to Overcome in Order to Act on the Issue

The most critical need at this point in time is to immediately begin to increase graduation rates from our schools of nursing. In order to accomplish this goal, the most pressing need is for more qualified faculty. A survey of nursing education programs conducted by the SC League for Nursing in 2004 revealed 32 current faculty vacancies with another 62 anticipated vacancies over the next 5 years due to faculty retirements. These figures do not account for unanticipated losses due to relocation, illness, taking another position, or other reasons. Only 6% of the nursing workforce is prepared at the Master's degree level, a requirement to teach in a registered nurse program.

A second barrier is the recruitment of qualified high school students into nursing and health care careers. Men and minorities are in particular short supply with men making up only 6% of the RN workforce and minorities only 12%. It will be impossible to increase the supply of the workforce without making significant increases in the numbers of males and minorities in the workforce.

A third barrier to overcome is the work environment itself. Strategies must be developed to retain aging nurses in the workforce. Technology incentives, shorter work hours than the typical 12-14 hour shifts, lift devices, and other ergonomic modifications must be made.

Finally, the fact that there is no centralized clearinghouse for maintaining information on what progress is being made on the workforce shortages, or what successful strategies are being implemented that could be replicated, is slowing the progress of SC to overcome this serious healthcare crisis. Many other states have created Centers for Nursing Workforce development that have done extraordinary work in finding grant funding to bring into the state to deal with their issues. The Centers have maximized their resources by building public/private partnerships to leverage their assets in dealing with the anticipated shortages. In SC every healthcare agency is concerned, and most are pouring money into what they think is best, but there is no master plan or oversight to assure the state is on the right track in reaching its goals.

III. Workable Solutions to Overcome Barriers

1. State Level:
    a. Establish a SC Center for Nursing Workforce Development to bring together a coalition of health care leaders to develop a statewide master plan that addresses the healthcare workforce shortages and seeks funding to target areas of greatest concern.
    b. Create incentives for SC graduate nurses to practice in designated shortage areas by offering loan-forgiveness/loan cancellation programs for each year employed in the designated shortage area.
    c. Provide scholarships or loan forgiveness programs targeted at BSN students to enroll in graduate education and agree to teach in SC nursing education programs.
    d. Provide tax credits to faculty who teach in SC nursing education programs.
    e. Develop and fund statewide recruitment programs that target men and minorities.
2. National Level:
    a. Fund Title VIII – Nurse Reinvestment Act – at the requested full funding level of $175 million. The Act enhances nursing education programs, targets faculty development, and provides tuition and loan assistance to students in advanced practice.
    b. Continue to urge philanthropists such as the Kellogg Foundation, Robert Wood Johnson Foundation, Johnson and Johnson Foundation, and others to create incentives and grant opportunities for states to bring together coalitions to address the long-term issues of adequate health care resources in the future.

IV. Recommendations

1. Formulate legislation to create a SC Center for Nursing Workforce Development with a state-appropriated funding similar to that of the NC Center for Nursing. The

workforce shortage is a long-term issue and will require long-term solutions and monitoring to avert a public health crisis in our state.

2. Propose legislation in the form of the South Carolina Nurse Shortage Reduction Act that would immediately earmark funds to increase the capacity of nursing education programs in our state and to retain the current workforce by providing tax incentives and loan cancellation programs.

Healthcare Workforce Shortages

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Workforce Issues: The Need for Geriatricians

By

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Workforce Issues:
The Need for Geriatricians

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Statement of the Issue:

There is a severe shortage of Geriatricians and Geropsychiatrists; this shortage will get worse.

Aging of our population will dramatically affect all aspects of health care, including the need for expert care by Geriatricians. While most care of seniors will be delivered by generalists (General Internists, Family Practitioners, and General Practitioners), there will be a need for Geriatricians to care for complex older patients. Presently, there are far two few Geriatricians to care for older adults: estimates range from a shortage of 5-20, 000 with the numbers needed dramatically increasing over the next 30 years.

Presently, South Carolina has an estimated 30 Geriatrically trained physicians to care for approximately 510,000 age 65 and over, for a ratio of 17,000:1 geriatrician. Yet, geriatricians can often provide the best and most cost efficient care for these adults. The American Federation of Aging Research estimates that if proper Geriatric care could result in a reduction in hospital, nursing home, and home care expenses of just 10%, the savings would have saved more than 50 Billion in health care in the year 2000. Estimates form the SC Lt Governor's office on Aging are that even a 1% savings in could mean $1 Million per week in savings that could be invested in preventing many age associated diseases and conditions.

Identification of Barriers:

Presently, USC/ Palmetto Health have 4 geriatric fellowship training positions and MUSC has 2 geropsychiatric fellowship positions – yet even these few slots remain unfilled due to lack of qualified applicants. Despite Geriatricians having the highest job satisfaction of any specialty [**ref**] there is a paucity of qualified applicants. Why don't more physicians choose Geriatrics as a career?

There are multiple reasons why physicians don't enter Geriatrics and Geropsychiatry. Some, such personal professional preferences, are inherent in both the potential trainee and the specialty of Geriatrics. However, one of the largest barriers to students selecting a career in Geriatric Medicine is financial.

There is little or no difference in reimbursement through the Medicare system for care provided by a certified Geriatrician compared to other generalists. Reimbursement for caring for seniors is comparatively poor, especially for physicians who care for complex frail patients. A general internal medicine or family medicine resident that

decides to enter a geriatrics fellowship for one year, actually risks seeing their income fall because they sought extra training!

Even altruistic physicians, willing to accept a decline in salary, are dissuaded from entering Geriatric Medicine because of the large burden of educational debt they have incurred. The average medical student educational debt nationally is $109,456, 25% have loans excess of $150,000.

Proposed Solutions:

1. Efforts should be made to create financial incentives to encourage physicians to train in, and practice, Geriatric Medicine and Geropsychiatry.
2. There should be differential reimbursement on the part of Medicare that will significantly reward those who have certification in Geriatric Medicine and Geropsychiatry.

Recommendations to the Conference:

1. Actions at the Federal Level:
    a. Medicare reimbursement should be revised to reflect an increase of at least 30% to practitioners who have practices that have at least 75% Medicare patients and also are certified or fellowship-trained in Geriatric Medicine or Geropsychiatry.
    b. Strong incentives to train Geriatricians and Geropsychiatrists should be developed by increasing reimbursement through the graduate medical education funding mechanism of Medicare.
    c. Additional incentives should be created to expand the numbers of academic Geriatricians, so that faculty will be available to train practicing Geriatricians. These include expansion of existing programs for junior faculty, and development of career awards for mid-level and senior faculty in educator tracks as well as research tracks.
    d. All specialties that provide for care of older adults should have specific curriculum in aging and competency standards in the care of older adults.
2. Actions at the State Level
    a. The Geriatrician Loan forgiveness act, presently being considered by the South Carolina Legislature should be approved and fully funded.
    b. Additional incentives to expand Academic Geriatric and Geropsychiatry training programs should be implemented at both USC/Palmetto Health and MUSC. Additional funding for these initiatives should be provided through the state legislature. These initiatives should focus on expanding faculty resources to provide both education and research related to improving the care of older South Carolinians.

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Community Forums Report

(D)
Workforce Issues

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

WORKFORCE

LOCATION OF EVENT: Florence Civic Center – Florence, SC

Priority Issues:

J) Opportunities for older workers/retraining
K) Coming shortage of trained workers
L) Shortage of workers for senior services
M) Significant need to develop the geriatric healthcare workforce

Proposed Solution(s):

H) As we anticipate the wave of Baby Boomers who are nearing retirement age, preserving the value of their pension plans is crucial. Recommendations to retain older workers and encourage their reentry into the work force must be seriously considered. (It is anticipated that a dramatic decrease in younger workers will jeopardize the adequacy of America's work force.)
I) Encourage the nation's employers to develop business models for recruiting and retaining mature workers.
J) Improve the effectiveness of One-Stop Career Centers to connect mature workers to employment and training opportunities.
K) Eliminate penalties to low-income older workers who rely on scarce employment and training opportunities.

LOCATION OF EVENT: Emmanuel Baptist Church – Manning, SC

Priority Issue:

Senior education and training/retraining.

Barriers:

1) Insufficient jobs available for people 55 and over who need to supplement their income.
2) Not enough money for needed senior training programs, especially for computer classes.
3) Insufficient training facilities.

Proposed Solution(s):

1) Develop affordable and readily available senior education/training programs that use job shadowing, work keys, and vocational rehabilitation training.
2) Broader communications between different agencies to determine availability of classes and on-the-job training opportunities.

LOCATION OF EVENT: Kershaw County Health Resource Center – Camden, SC

Barriers:
1) There is a gap in availability of a strong healthcare workforce.
2) There are no work options for adult caregivers who need to work.
3) There is a need for younger skilled workers to replace the many seniors that will be retiring in the near future.
4) Lack of incentives for younger workers and available resources.

Proposed Solution(s):
1) Promote job sharing to increase options for seniors.
2) Promote a flexible schedule for seniors who are required to provide child care/adult care to families; also, consider allowing seniors to work from their homes if possible.
3) Provide incentives for companies to locate here to increase job options.
4) Establish mentoring/job shadowing programs; consider intergenerational and peer groups.

LOCATION OF EVENTS: The Shepherd's Center – Sumter, SC

Priority Issue:
The retraining of an older workforce and options to enhance/encourage continued employment.

Barriers:
1) General high unemployment.
2) Age discrimination.
3) Lack of affordable training opportunities.
4) No alternative training or non-traditional training programs.

Proposed Solution(s):
1) Establish non-traditional, senior focused training opportunities for older adults.
2) Provide business incentives to hire mature workers.
3) Encourage businesses to offer flexible work place options (job sharing, work schedule).
4) Educate employers on benefits of hiring mature workers (stability, reliability, strong work ethics, and life experiences, etc.).
5) Make vocational counselors available to encourage older workers.

LOCATION OF EVENT: Bethlehem United Methodist Church – Bishopville, SC

Priority Issue:
Older workers in the workforce.

Barriers:

1) Age discrimination.
2) Health issues.
3) Skill level of older workers, lack of current technology.
4) Transportation for seniors to get to work.

Proposed Solution(s):
1) Educate employer concerning the assets of the older workers.
2) Provide free healthcare for elderly.
3) Provide free or affordable senior training and specialized training.
4) Establish a vanpool to provide specialized transportation for seniors (consider applying for a grant).

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
Jobs (employment) and volunteer opportunities for senior citizens.

Barriers:
1) Lack of resources.
2) Transportation.

Proposed Solutions:
NOT ADDRESSED IN PACKET.

SOUTH CAROLINA
WHITE HOUSE CONFERENCE ON AGING

April 25-27, 2005

(E)
Health Care

Issue Papers

Springs A-C

Prevention and Wellness "Among" Older Americans

By

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Prevention and Wellness Among Older Americans

Issue: Americans are living longer, and the proportion of older adults in the population is increasing rapidly. By 2030, 70 million Americans or 1 in every 5 will be 65 and older. The trend in South Carolina is consistent with the national trend. In 2000 in South Carolina, there were 485,300 persons aged 65 and older, a number that has increased by 100,000 every decade from 1950 to 1990, and by 90,900 from 1990 to 2000. The over-85 age group is growing at an even more rapid rate. By the year 2025, estimates are that the number of people over 85 in SC will reach 98,609, representing a 96 percent increase from 2000.

The demographic shift toward an older population places increased demands on the public health, medical, and social service systems. Countless older Americans suffer from chronic diseases, the leading causes of death and disability. Chronic diseases can cause years of pain, suffering, and disability, and can lead to extensive medical and long-term care expenditures before ultimately resulting in death. The human and economic impact is enormous. Eighty percent of people 65 and older are living with at least one chronic disease. The average 75 year old has three chronic conditions and takes five prescription medications. Arthritis, the leading cause of disability in the nation, affects nearly 60% of adults aged 65 and older. The diabetes rate for the 65 and older age group in SC is 7-8% higher than for the 45-64 year old age group, and the diabetes death rate for older adults is more than 4 times higher. The death rate from cardiovascular disease, the leading cause of death in SC, is 5 times higher among people 65 and older than among people ages 45-64. For all types of cancer, the rate for adults 65 and older is almost 9 times higher than for younger populations. For prostate, lung, and colon cancer, the difference is even more pronounced. For many diseases and conditions, racial disparities make the burden of chronic disease even greater for African Americans in SC.

Although the risk of chronic disease, disability, and death increases with age, "poor health or disabilities are not inevitable consequences of aging (CDC)." Many older adults suffer needlessly from chronic diseases that can be prevented or delayed. Scientifically proven preventive measures, such as healthy lifestyle behaviors (eating healthy, avoiding tobacco use, and exercising regularly) and clinical preventive services (influenza and pneumonia vaccinations and early detection of disease through screening) can extend life and preserve quality of life. It is never too late to make behavior changes. Simple health promotion practices, such as regular physical activity, can prevent many chronic diseases and make it possible for older adults to remain at home in their own communities. Use of prevention measures would substantially reduce the personal, familial, social, and economic costs of aging and would lead to healthy and productive years of life for the growing population of seniors. Public health and aging professionals should be at the forefront of developing approaches to help older adults put into practice these simple measures to enjoy healthy aging.

Barriers: While there is ample evidence of the benefits of prevention strategies, knowledge has not yet been turned into action. Current resources are not adequate to address the population boom of older adults that is facing America. Evidence-based prevention and wellness programs

are still not commonplace, especially in rural areas. Programs that do exist often have fees attached, preventing those most in need from participating. Furthermore, public health initiatives targeted toward prevention measures for older adults are limited due to lack of federal and state funding to support such initiatives. The challenge is to develop prevention programs that are accessible to older adults of all races, ethnic backgrounds, and interests.

While there has been some movement toward prevention approaches, for the most part, health care is still based on a traditional fee-for-service treatment approach, rather than a prevention focus. Until the health care system makes dramatic changes in coverage and provides incentives for health care providers to prescribe prevention approaches, access to prevention services will continue to be limited.

Like the health care system, many social service programs focus on treatment, rather than prevention and supportive services, such as respite care for family caregivers. It is not uncommon for individuals and their families to be forced to seek institutionalization because there are no programs to support family caregiving efforts. While social support is a key factor for positive mental health and healthy aging, enhancing support from family and friends and developing social networks are often overlooked in social service programs.

Solutions: To address the challenges posed by an aging population, the traditional health care focus of treating disease and extending life, regardless of its quality, must shift to one of preventing disease and disability and improving quality of life. Making healthy aging a reality will require an integrated approach that includes research, education, expanded public health and aging initiatives, improved medical practices, community planning, and social service programs that support aging in place. Additionally, aggressive health communication and outreach efforts are needed to overcome disparities and to make prevention practices widely available and accessible to all population groups 65 and older throughout SC.

Further research is needed to develop scientifically based prevention programs that are accessible to older adults of all races, ethnic backgrounds, and interests. Health policy changes are also needed to support proven prevention measures and to make them widely available. National policy that supports states in expanding health promotion and disease prevention programs is critical, along with designated funding for these programs.

In addition to research and policy change, considerable revisions are needed in the health care delivery system to promote and expand prevention practices among older adults. The use of prevention, screening, and early detection services, along with immunizations against influenza and pneumonia, must be expanded to improve years and quality of life. Primary and geriatric care practices should routinely include health education and chronic disease prevention counseling, and referral to community resources that prevent institutionalization and support healthy aging in an individual's natural environment. There is already overwhelming evidence that such an approach would save lives and significantly reduce health care costs.

To adequately address the growing aging population, social and environmental issues can

not be ignored. Community design and transportation may support or create barriers to healthy behaviors. For example, whether there are sidewalks, whether neighborhoods are safe, or whether public transportation is available to access programs and services are factors that must be considered and incorporated into a comprehensive approach to increase years of healthy living.

The extent and quality of social relationships are critical factors in determining the physical and mental health of older adults. Social service and health programs should develop strategies to strengthen and expand existing natural support networks in the community to promote aging in place and prevent institutionalization. For example, the provision of supportive services for family caregivers would prevent or delay institutionalization in many cases and would result in significant cost savings. Rather than operate in isolation, social service and health programs should collaborate with community design and planning organizations to create an integrated approach for aging in place that fits the needs of the community.

Recommendations: Immediate attention is required at the national level to make state prevention programs a reality. For South Carolina and other states to develop and put into action statewide prevention plans for older adults, federal support and funding are critical. Public policy changes are needed to redirect the current medical model of health care toward an integrated approach that incorporates disease prevention and health promotion measures. Funding of healthy aging programs should be a Congressional priority. Taking action now would increase the quality and years of life for many older adults and would save substantial health care dollars in the future. With support from Congress, the Centers for Disease Control and Prevention (CDC), in collaboration with the Administration on Aging (AOA), is positioned to take the lead in helping states develop plans for healthy aging and build capacity for sound, scientific-based prevention programs. With additional support, CDC and AOA have the expertise to serve as resources to state aging and public health programs for consultation, training, technical assistance, and replicable, scientific-based prevention programs.

The state of South Carolina must also make prevention a priority, providing legislative support and funding for health promotion and prevention measures to increase healthy years of life.

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www.cdc.gov/aging

www.cdc.gov/nccdphp

www.scmatureadults.org

The Impact of the Growth of the Senior Population on Health Care Access and Delivery in South Carolina

By

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Issue Statement: The impact of the growth of the senior population on health care access and delivery in South Carolina.

Statement

Many seniors are quick to tell you that a large part of their daily life is spent going to the doctor's office or going to get medicine prescribed by their doctor. While great progress is being made on keeping aging adults independent and enjoying a higher quality of life, both our state and national healthcare delivery system is soon to be overwhelmed by the aging baby boomer generation. Consider the rapid in-migration of seniors to SC; the challenges may well be magnified in SC. At present, SC is the fastest growing state in the Southeast and 5th overall for in-migrating seniors in the United States.

The overwhelming responsibility of caring for tomorrow's senior citizens will primarily fall squarely on the shoulders of Medicare (federal government insurance for those >65 and the disabled) and Medicaid (a state/federal program which provides health insurance for the state's poorest citizens).

Barriers

There are signs that our current health care delivery system is collapsing under the weight of unreimbursed or under-reimbursed care. The problem is not primarily the fact that the number of uninsured in America is on the rise. No, the current erosion into quality health care is primarily driven by the under-reimbursement for health care services by governmental payers – Medicare and Medicaid. It is expected that by 2014, about 50% of every dollar spent on health care will originate from our governmental payers. Our state and federal legislators, continue to promise preservation if not expansion of the existing Medicaid and Medicare programs to meet the needs of the poor and elderly. Unfortunately, the political promises are often being fulfilled on the backs of nurses, doctors, as well as the facilities committed to care for the elderly.

Fewer physicians are choosing to practice in fields that provide vital services due to escalating malpractice insurance and declining reimbursement. Medicare and Medicaid reimbursement is so low that many physicians are having to limit or close their doors to Medicaid or Medicare patients to keep their own doors open. Many are opting out to practice boutique medicine outside of insurance reimbursement limitations. It is important to remember that even if adequate numbers of physicians have been trained to provide vital primary medical care, unless it is economically viable to perform the service, the service will not be provided. The current delivery system encourages early retirement of more skilled physicians who are having difficulty in finding coworkers willing to provide vital medical care under difficult conditions.

The long-term care industry is presently suffering under the same constraints of low government reimbursement and escalating malpractice insurance cost. Nursing homes have become the new target of the litigation system. The average cost per year nationwide of insuring an occupied skilled nursing bed has increased from $240 in 1996 to $2360 in 2001, and the rate of increase in South Carolina is reported to be even greater. The majority of these costs are borne by the tax-

paying public. In addition, state run liability insurance coverage (SC Joint Underwriting Association) is not available to long term care providers in South Carolina. The decreasing number of private liability insurers has caused higher insurance premiums for less coverage.

Federal and state regulations over long-term care have become overwhelming, not only for the long term care providers but also for the physicians caring for patients in these facilities. Federal and state regulations, along with low Medicaid and Medicare reimbursement have led to a system where the most viable alternative for long term care providers is private pay only. Unfortunately, this does not help our most vulnerable, indigent citizens.

Approximately 70% of the state's Medicaid dollars are spent treating the aged, disabled and blind. Our strategic goal should be to allow this population to age in place and avoid expensive out-of-home and institutional care. However, the fact is that 47% of individuals over 85 suffer from dementia and in the future, more families will find long term care the most viable option for appropriate care of their confused loved one.

Currently, every household in South Carolina pays $485 for tobacco related health care costs every year. This year, a Harvard University study showed that approximately, 40% of US citizens declared bankruptcy because of $10,000 of medical bills. If you consider that every household puts about $500 into the tobacco pit every year, by age 40, a citizen would have put about $10,000 into the tobacco pit; probably, about the time the health care bills might catch up with some families.

Workable Solutions

There is presently a three-year waiting list for students interested in becoming a licensed practical nurse because South Carolina has been unwilling to commit to providing nurse educators for our technical colleges. According to Donald Strunk, economist, from the Darla Moore School of Business, nurses are the health care professionals most needed in a new grayer South Carolina. Recently, The State newspaper series on the nursing shortage in South Carolina pointed out that graduate level nurses need to be recruited out of the private sector to teach nursing students. The article pointed out that nurse educators' annual salaries need to increase by $10,000-$20,000 to make teaching nurses competitive with private practice salaries.

Increasing the cigarette tax in South Carolina is the better solution. Recent studies show that the best way to avoid dementia is to care for your heart through healthy living. Vascular disease is the predominant cause of dementia. Cigarette smoking is a major cause of vascular disease. According to the Centers for Disease Control Study, released in May 2002, $6.52 was spent on tobacco related health care and long-term disability costs for each pack of cigarettes sold in South Carolina. Most recently, Frank Sloan, economist at Duke University, published a book, THE PRICE OF SMOKING, outlining a more comprehensive analysis of the cost of cigarette smoking in our society. He concludes that every pack is costing society $40; $33 for the smoker; $5 for the smoker's spouse; and $1.50 for the passive smoker exposed to tobacco smoke. It is understandable that the business community, which is attempting to provide health coverage for

their employees, and the healthcare delivery system, which is collapsing under the weight of un-reimbursed care, are in support of shifting this burden to the tobacco user.

Recommendation for Action

A substantial cigarette tax increase could bring in much needed revenue for a faltering healthcare delivery system, decrease adult use (4% for every 10% increase in per pack cost) and teen initiation (7% for every 10% increase in per pack cost), and immediately save tobacco related health care costs. In fact, a person's risk of heart attack and stroke declines within a week of the elimination of smoking. Based on studies from the other 30 states which have passed a cigarette tax increase, simply raising the cigarette tax to $1.00 in South Carolina would save $15 million over five years by preventing heart attacks and strokes alone.

The challenges that lie ahead for South Carolina must be addressed at once to avert a societal crisis as our in-migrating and native citizens in the baby boomer generation turn into octogenarians. There is no better solution than a substantial increase in South Carolina's meager seven cents per pack tax on tobacco.

Improving the Health of South Carolina's Minority Seniors

By

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"IMPROVING THE HEALTH OF SOUTH CAROLINA'S MINORITY SENIORS"

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Statement of the Issue

As a group, African-Americans live sicker and suffer more than other groups from a number of long-term illnesses. Illnesses like cardiovascular disease, including heart disease and stroke, and diabetes are more common in the African-American community. For example, of those 65 and older, African-Americans are *twice* as likely to report having diabetes and *four times* more likely to die from diabetes than Whites. Older African-Americans are also less likely to receive the recommended vaccines against the flu and pneumonia, making them more likely to have complications and die from these conditions. These differences in health status are known as health disparities. Health disparities really point to differences in the burden of disease and illnesses experienced between population groups. Health disparities may be seen as differences in developing a health problem, becoming sick or being hospitalized for a health problem, or death due to a health problem. In addition to poor quality of life, health disparities and poor health among the state's minority seniors also contribute to rising health care costs and increasing financial obligations at the federal and state levels and for families. South Carolina is working toward eliminating health disparities as a priority. The Department of Health and Environmental Control (DHEC), the state's leading health agency is committed to improving the health of all South Carolinians through the Healthy People 2010 goals. The two overall goals are: 1) Increase the quality and years of healthy life and 2) Eliminate health disparities. The DHEC Office of Minority Health serves as the agency's principal advisor on minority health issues.

Barriers

Differences in access, health care and quality, healthcare providers and information contribute to the health disparities among racial and ethnic minorities. A major barrier to eliminating health disparities among minority seniors is access to health care. Access depends on three factors: economic, physical, and cultural. Examples of economic factors are: affordability and inability to pay, either directly or through health insurance. In South Carolina, minorities are more likely to live in poverty than Whites. As minority seniors are more likely to live in poverty and have higher medical costs, these factors put an additional strain on families and may affect medication compliance. Some physical factors are the physical distance from health care services, the hours of operation, number of doctors, and inadequate transportation, especially in rural areas of South Carolina. Furthermore, the lower quality of healthcare for African-Americans, as documented in

the Institute of Medicine report, "Unequal Treatment; Confronting Racial and Ethnic Disparities in Health Care" proves to be an additional barrier to quality health care for many minority seniors. Cultural factors among the senior minority population may also serve as a barrier to health care. There are cultural differences in the values, beliefs, and traditions of African-Americans and other cultural groups. Cultural factors also influence communication between healthcare providers and the senior minority population. Memories of the infamous Tuskegee Experiment and other negative encounters experienced by some minorities may still continue to contribute to a culture of mistrust, especially among minority seniors. A lack of information about availability and eligibility to health care services can also serve as a barrier to access among the senior minority population.

Workable Solutions

Consideration of cultural differences is critical to policy development, planning, and providing health services to the senior minority population. Cultural competence has a significant impact on the quality of health care and service delivery to meet the needs of minority seniors. Cultural competence means understanding and respecting cultural differences. Cultural competence among healthcare providers requires putting behaviors and attitudes into practice to assist in working more effectively with patients of all cultures. Cultural competence training can improve quality of care for minority seniors as health care providers learn to pay special attention to differences in how a disease develops and treatment of disease. Cultural competence training can also contribute to the elimination of health disparities by improving communication between health care providers and senior minority patients. Cultural competence not only addresses language barriers but also involves enhanced understanding and trust of the health care system among minority seniors. Large health institutions should have culturally competent guidelines and policies to support equality of health care and enforce those policies.

Increased number of minorities in the healthcare professions can improve quality of health care and treatment of minority seniors. Through programs that help minorities enter into the health professions, more minority health care providers will be able to practice in minority communities. More programs are needed to recruit, train, and retain minorities in the health care professions. By practicing in medically underserved areas, minority health care professionals can have a significant impact on the health of minority seniors. A diverse and well-trained workforce can improve efforts to reach minority seniors and address health disparities in communities of color.

Partnerships with churches and other community organizations are also needed to eliminate health disparities and improve the health of minority seniors. Just as programs designed for the general population do not meet the needs of the general elder population, programs designed for the general elder population do not meet the needs of the senior minority population. A "one-size-fits-all" approach to designing service programs will not work. By working with churches and other community groups more effective ways can be found to reach minority seniors based on their values, beliefs, and traditions. Such partnerships can strengthen efforts to provide more culturally appropriate and accessible health care and promote greater understanding of the health needs of minority seniors. These partnerships can also enhance advocacy efforts to support

environmental and policy changes for prevention and healthy lifestyles. By combining the resources of diverse partners, improved access to health and social services can be provided to senior minority populations, especially in rural areas of South Carolina.

Lifestyle habits and heredity also impact health disparities. Even though family history of illness can increase the likelihood of developing some conditions, poor health is not an inevitable outcome of aging. Culturally appropriate programs including culturally competent outreach strategies can improve understanding of behavior that increases the risk of developing disease and how to improve quality of life. These programs can also increase the ability of minority seniors to take active roles in their health and health care. Such programs can provide the education and training needed for minority seniors to become informed health consumers. By taking steps to be more physically active and choosing healthier diets, more of South Carolina's minority seniors can enjoy longer, healthier lives.

Recommendations

To overcome barriers to healthcare among the senior minority population, the issues of access and cultural competence need to be addressed.

Access:

- Greater access to and availability of health care services, especially in rural and medically underserved communities will make a difference in the health status of minority seniors.
- Extended office hours, transportation, and affordability of health care services are needed.
- Healthy lifestyles should be encouraged through community programs and safe places to walk and be physically active should be part of neighborhoods.
- By increasing the number of minority healthcare professionals, especially in rural communities, the senior minority population will have greater access to culturally competent health care services.

Cultural competence:

- Communities should work together to make sure that policies, programs, and health care services are culturally competent and meet the needs of minority seniors.
- The issues of mistrust and fear should be addressed to encourage more minorities to seek health care before they get sick.
- The participation of more minorities in clinical trials and research are needed to increase understanding of health disparities and provide recommendations for elimination.
- Cultural competence training should be required for all healthcare professionals.

Medical Malpractice Caps

By

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HEALTH CARE ISSUE PAPER – Jan Warner

Medical Malpractice Caps: Necessary or governmental myth to further control the middle class? Should the government place itself in the shoes of the jury which is made up of the same people who elect it without promising reduced health care, prescription drug, and health insurance costs?

Contrary to the governmental pitches and public relations, limiting medical malpractice awards will not lead to successful health care cost containment, but will hurt middle class and lower income families -- especially seniors – who may deserve compensation.

By taking away the threat of medical malpractice suits and limiting damages, the government will take away the incentive to deliver the best health care product possible. Remember Ford Motor Company and the exploding Pinto?

To contain health care costs, the government must reform the manner in which health care services are delivered, not limit compensation for injury and death. For example, although waste runs rampant in our health care system, including high administrative costs, there are no governmental efforts being made to fix it. And while our health insurance premiums continue to skyrocket along with the cost of drugs and medical care, the government blames the debacle on lawyers and medical malpractice claims because lawyers, seniors, and middle class people are easy targets for the current administration.

Caps on lawsuits will hurt already injured patients and their families. Is the government offering you a reduction in your prescription drug bill, your doctor bill, your hospital bill, and your health insurance bill if caps are placed on medical malpractice claims?

You have not, and your will not because caps will not lower doctors' liability insurance rates or your health insurance costs.

As usual, it is the American middle class family and senior against the well-funded lobbyists who are bent on further hurting injured patients and their families. Have you heard any cry by government that doctors' malpractice insurance premiums are too high, and they are finding legitimate ways to reduce medical malpractice premiums by getting the insurance companies to stop gouging the physicians? Of course not, even though it is warranted.

In the State of Washington, for example, Physicians Insurance, the state's largest medical malpractice insurer, was ordered to process refunds of more than $1.3 million plus interest to nearly 2,400 doctors. The highest refund is more than $4,600.

Under California's Proposition 103 that requires insurance companies to open their books and justify rate increases, the California Insurance Commissioner in 2003 required that state's second largest malpractice insurance carrier to reduce a proposed 15.6 percent increase to 9.9 percent, saving doctors millions of dollars of additional premiums.

Other states require prior approval by their insurance department before there can be rate increases on medical malpractice policies. How many more malpractice carriers gouge their policyholders? Every time there is a flood, a hurricane, or a 911, insurance rates increase – yours, mine, and doctors' because the insurance companies do not have enough reserves and have not done well in the stock market. So, like the government that raises property taxes or other taxes when it needs money, every time they need more money, insurance companies raise premiums. How many of you have seen your homeowners' or automobile coverage increase even though you did not make a claim? How about your health insurance?

While insurance and medical lobbyists say there is an "explosion" in medical malpractice claims, the rise in claims is nowhere near epidemic proportions, but in the vicinity of five percent per year.

The president, congress, and state legislatures are on a crusade to get rid of "frivolous" lawsuits to compensate the elderly and middle class, leaving them as targets. If you want to talk about "frivolous," look at the trade deficit, sending jobs out of this country, reducing what seniors have been promised, eating up Social Security increases with Part B premiums, and passing tax laws that help the wealthy and the corporate giants, but not seniors. How many of you have saved money because of the dividend tax cut? How many of you even have stock accounts? How many of you will save money if the estate tax is repealed – that is, how many of you and your spouses have more than $3 million today?

The current governmental environment is bent on protecting insurance companies and corporations from 'frivolous lawsuits' by ordinary citizens, but not protecting ordinary citizens from health, safety, and quality of life problems to which they turn a blind eye.

The same government that paid newspaper columnist Armstrong Williams two hundred and forty thousand dollars of our money to promote the 'No Child Left Behind' initiative is paying plenty to jeopardize seniors' right.

When government has gone from plus $2.4 Trillion to minus $5 Trillion deficit on the backs of the middle class and seniors, it has little room to talk about reform until it gets its own house in order.

When government cuts $22 billion in estate taxes from the wealthiest one percent of the population so it can reduce Medicaid benefits needed by our seniors by $60 billion, veteran's benefits by $16 billion, and educational programs so only the wealthy can be educated, it appears they need to get their house in order before they start infiltrating other areas to help big business.

Our court systems weed out bad cases and have the authority to exact sanctions against the lawyers who bring them. This is the way in which to remove non-meritorious claims from the system, not be limiting the compensation a jury can award to victims of malpractice. Even though the cost of caring for disabled child for a lifetime will cost millions of dollars, that is irrelevant. Government wants to cap all awards. That is not fair.

Bottom Line: Every time the government tells us it is going to benefit us, it should be required to show us the economic benefit or reverse what it has done. Rather than legal reform, we need government reform.

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Community Forums Report

(E)
Health Care

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

HEALTH CARE

LOCATION OF EVENT: Florence Civic Center – Florence, SC

Priority Issue:

N) Access to services and affordability
O) Need to enhance and encourage health lifestyles/disease prevention
P) Addressing the cost of healthcare premiums and pharmaceutical costs

Proposed Solution:

L) As the wave of Baby Boomers approaches Medicare's eligibility age, it will become increasingly difficult for the federal government to fund this program without passing along more of the costs to consumers. The Medicare program must be strengthened. Over 40 million older and disabled Americans rely on the Medicare program for their health insurance. Across the board, we need to strengthen the traditional fee-for-service Medicare program for those who will continue to rely on it, even as other types of coverage options are expanded.

M) There are inadequate numbers of qualified service providers in this region, particularly in rural areas. This impacts an older person's choice regarding from which provider they would like to receive services.

LOCATION OF EVENT – Gaillard Municipal Auditorium – Charleston, SC

Priority Issue:

Healthcare services in the Trident area are limited to seniors because access to care is often unavailable and unaffordable. Healthcare service providers have minimal training in geriatrics and lack incentives to serve older adults.

Barriers:

1) Limited access to care (i.e., transportation to medical, dental, and/or eye care appointments);
2) High cost of prescription drug;
3) Lack of knowledge about services and programs; and
4) Minimal training of the medical community on aging.

Proposed Solutions:

A) Involve the faith-based community to assist in increasing knowledge about

healthcare resources available to seniors and to increase access for medical, dental, and/or eye care appointments.

B) Urge interest groups to advocate for increasing expanded healthcare benefits and providing more money for healthcare services.

N) Encourage health professional boards and associations to offer incentives for healthcare providers who receive geriatric training.

LOCATION OF EVENT: Fennell Elementary School – Yemassee, SC

Priority Issue:

Cost of healthcare premiums and pharmaceutical costs; access/affordability of services; need to enhance/encourage healthy lifestyles/disease prevention; transportation.

Barriers:

1) Costs of pharmaceuticals out of reach of most seniors on Social Security; new card does not help enough – deductible too high – too complicated to understand;
2) There are no limitations and no uniformity in doctors/hospital costs;
3) Not enough medical providers nor participating Medicare providers in rural and impoverished areas;
4) Levels for Medicaid for seniors too low and do not have realistic guidelines to consider for costs of housing and other expenses related to aging.
5) Transportation non-existent/too expensive in rural areas to travel to doctor appointments.

Proposed Solution(s):

1) States be allowed to bargain for bulk purchasing of pharmaceuticals and/or purchase from Canadian suppliers and pass on savings to seniors.
2) Government set profit limits for insurance companies and pharmaceutical companies.
3) Government increase Medicaid payment scale for doctors and hospitals to better meet costs of overhead.
4) Offer tax and financial incentives to encourage medical providers to work in impoverished and rural areas.
5) Re-evaluate Medicaid eligibility limitations to allow for more realistic costs for housing and other living expenses.
6) Allow non-Medicaid patients to pay for seat to ride on Medicaid buses to and from doctor appointments.
7) Offer more financial incentives to faith-based community to provide mobile units using volunteer drivers in rural areas; provide affordable insurance protection to volunteers in such roles; expand Good Samaritan Law to cover volunteers.

LOCATION OF EVENT: Capital Senior Center – Columbia, SC

Priority Issue:
Lack of access to services, equipment, prescription medications; insurance gaps and coverage; education – health literacy (awareness, prevention); lack of funding – ways of directing funding, shifting, broader coverage; advance directives.

Barriers:
1) Not spending enough on aging issues.
2) White House Conference on Aging (WHCoA) – every ten years is not enough; discussions not addressing specific issues.
3) Education/Communication – "Early" awareness (take away negative re: dying).

Proposed Solution(s):
1) Develop strategies that encourage and increase insurance carriers including Medicare, to cover previous services and reimburse for a) preventive services and equipment t hat support previous services; and b) healthy lifestyle behaviors.
2) Initiate, at the federal and state levels, a shift from high-tech services to community based low-tech, preventive services.

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
1) Access and education of available services;
2) Complexity of process for medical care and billing/copay;
3) Medication cost, drug cards;
4) Cost of insurance/healthcare, cost of medical care and services;
5) Need for geriatric doctors;
6) Increase funding for Medicare/Medicaid;
7) Availability of in-home services.

Barriers:
1) Transportation, cost, education on what's available, generic vs name brand, reluctance to ask for assistance, sensitivity of doctor in cost of medication.
2) Health care is complex, lack of education, and interaction of insurances.
3) Understanding what you are buying, lack of coverage, availability of coverage, need to research.
4) Complex systems – unable to talk with a person, reluctant to explore services, waiting for a crisis.
5) Lack of geriatric doctors, transportation.
6) Lack of funding those that fall through the cracks, no insurance.

Proposed Solution(s):
1) Home delivery of meds (ask for samples from doctor, ask for generic meds).
2) Simpler system – assistance from doctors' office with forms, etc.
3) Uniformity of products, insurance counseling (I-Care).
4) Pre-planning education, one Stop Shop, take information to the seniors/community.
5) Find funding for doctor to provide in home care, going to the patient.
6) Pull from churches and communities.

LOCATION OF EVENT: Pinckney Hall, Sun City Hilton Head – Bluffton, SC

Priority Issue:
Cost of health care premiums and pharmaceutical costs; access and affordability of services; need to encourage/enhance healthy lifestyles and disease prevention.

Barriers:
1) Prescription drug costs too high even with new drug card due to high deductible and other limitations.
2) Medicaid waiver and/or guidelines do not safeguard middle income seniors' assets.
3) Medical expenses continue to rise, in part due to high cost of malpractice insurance.
4) Excessive incidental charges by hospitals too high, running up billing to insurance companies and consumers.
5) Spend down rules exhaust retirees' assets before help from Medicaid.
6) Corporations are cutting medical benefits for retirees.
7) Drug costs are elevated due in part to advertising costs.
8) Caregivers of elderly parents are not protected with parental leave law.
9) Medical billings are too complicated and confusing for seniors.
10) Shortage of geriatricians prevents adequate health care in rural areas.

Proposed Solution(s):
1) Outlaw drug advertising in media; and require pharmaceutical companies to pass savings on to consumers; have FCC monitor to ensure compliance.
2) Review and increase Medicaid eligibility requirements to better reflect cost of living to serve more seniors.
3) Place profit ceiling on medical providers and pharmaceutical companies.
4) Have more aggressive monitoring of billing practices of medical providers.
5) Review spend down rules to reflect more accurate cost of living for seniors.
6) Stop subsidizing tobacco farmers and use the savings to increase funding for senior services.
7) Implement Parental Leave Act as part of Older Americans Act to protect caregivers who are caring for frail and elderly senior parents.
8) Provide financial support and tax breaks for caregivers of seniors.
9) Encourage more geriatric practices in rural areas with tax incentives and student loan waivers.
10) Fund more aggressive training for physicians and their staff to help seniors access services and information on diseases.

11) Provide more readily available assistance to seniors with medical billing confusion.
12) Provide Tort controls to limit malpractice liability; limit cost of malpractice insurance.

LOCATION OF EVENT: H. Odell Weeks Activity Center – Aiken, SC

Priority Issue:
Seniors, in the primarily rural Lower Savannah Region of South Carolina, have difficulty accessing health care services to maintain or improve their overall health. Very often, medical services are unavailable.

Barriers:
1) Limited transportation to medical appointments for seniors of all economic levels.
2) High cost of prescription drugs and confusion about the prescription drug cards.
3) Lack of knowledge about health services and programs.
4) Lack of health education for disease prevention/health promotion, and good nutrition.
5) Lack of physicians and specialists to meet the demand in rural communities due to high malpractice insurance cost.
6) Lack of available assistance to seniors for medication management due to liability concerns.

Proposed Solution(s):
1) Partnerships with agencies that provide transportation at affordable costs.
2) Increase education programs for seniors through agencies and t he faith based organizations.
3) Increase health promotion/disease prevention education.
4) Tort Reform/controls on medical malpractice insurance premiums.
5) Increase knowledge and assistance for seniors in need of medication management.
6) Increase knowledge to the communities about Medicare Part D and other prescription drug assistance programs that are available.

LOCATION OF EVENT: Orangeburg County Council on Aging–Orangeburg, SC

Priority Issue:
Seniors in the primarily rural Lower Savannah Region of South Carolina have difficulty accessing health care services to maintain or improve their overall health. Very often, medical services are unavailable.

Barriers:
1) Limited transportation to medical appointments of all economic levels.
2) High cost of prescription drugs and confusion about the prescription drug cards.
3) Lack of knowledge about health services and programs.
4) Lack of health education for disease prevention/health promotion, and good nutrition.

5) Lack of physicians and specialists to meet the demand in rural communities due to high malpractice insurance cost.
6) Lack of available assistance to seniors for medication management due to liability concerns.

Proposed Solution(s):
1) Partnerships with agencies that provide transportation at affordable costs.
2) Increase education programs for seniors through agencies and the faith based organizations.
3) Increase health promotion/disease prevention education.
4) Tort reform/controls on medical malpractice insurance premiums.
5) Increase knowledge and assistance for seniors in need of medication management.
6) Increase knowledge to the communities about Medicare Part D and other prescription drug assistance programs that are available.
7) Seniors should have the same health care as our Native Americans.

LOCATION OF EVENT: City Council Chambers – Rock Hill, SC

Priority Issue:
Seniors in the Catawba Region lack access to adequate health care.

Barriers:
1) Due to the expense of healthcare, doctors do not get to see senior patients until they are often already suffering from an illness.
2) Funding for wellness programs for seniors.
3) Seniors having to choose between healthcare and eating.
4) Medication and drug program changes effective for 2006 are very confusing.
5) People (seniors) who need the medicine do not have the power to make the decisions that need to be made.
6) Pharmaceutical industry spends more on marketing than they do on research.
7) South Carolina fazing out Silver Card at the detriment to seniors.
8) Changes to Medicare Program confusing.
9) The right to buy medicine cheaper. For example, buying medicine from Canada.
10) Changes that are being forced upon states by federal government will devastate seniors.
11) Seniors are the fastest growing population.

Proposed Solution(s):
1) Establish a task force to come up with intervention to deal with issues related to healthcare.
2) Need more funding for wellness for seniors.
3) Less expensive to provide basic medical care for seniors.
4) Competitive bidding process needed in the pharmaceutical industry to drive the cost of medicine down.
5) The ability to buy medicine in bulk would save seniors money.
6) Senior population should have clout given t heir growth rate and should use that clout.
7) We must insure that the senior voices are heard.

8) Keeping the caregiver's health is crucial to the care of the senior.
9) Networking is the key to being successful in assisting seniors.

LOCATION OF EVENT: Santee-Lynches Regional Council of Governments – Sumter, SC

Priority Issue:
Full range healthcare too expensive for the individual.

Barriers:
1) Cost of training practitioners/providers.
2) More value placed on profit than service.
3) Abuse of system drives up costs.
4) Laws and complexity of system to access benefits.
5) Malpractice insurance.
6) Many Medicare/Medicaid payments are not adequate.
7) Well or preventive care not usually covered by insurance.

Proposed Solution(s):
Offer affordable health insurance that fully covers: medical, dental, vision, hearing, mental health care, and medications.

LOCATION OF EVENT: Emmanuel Baptist Church – Manning, SC

Priority Issue:
Medicare/Medicaid going broke.

Barriers:
1) Increased aging population as people are living longer.
2) People demanding more services.
3) Lack of governmental funding.
4) Medicare/Medicaid fraud by providers; absurd charges.
5) Paperwork mistakes.

Proposed Solution(s):
1) More cost share by people who can afford it (perhaps higher premiums or deductibles).
2) Increase government funding.
3) More auditing of providers.
4) Restrict Medicare/Medicaid eligibility to U.S. citizens and those foreigners who are here legally.

Priority Issue #2:
Lack of participating providers who accept Medicare/Medicaid patients.

Barriers:
1) Sufficient allowable charges.
2) Inadequate funding.
3) Providers giving correct cost data.
4) Cost of malpractice insurance keeps prices high and reduces number of available providers.

Proposed Solution(s):
1) Obtain a realistic assessment of charges to ensure adequate allowable charges.
2) Provide incentives for providers.

Focus Group Concern: (1) Health programs/education for rural areas; (2) Age discrimination in health care system; (3) Affordable healthcare needed; (4) More preventive education; (5) More medical research needed; and (6) Insufficient geriatric doctors.

LOCATION OF EVENT: Kershaw County Health Resource Center – Camden, SC

Priority Issue #1:
Affordable medical care for seniors to include medications.

Barriers:
1) Upfront deductibles too high.
2) Inability for many people to understand their options (difficulty of applications).
3) Lack of award caps on lawsuits.
4) Cost of malpractice insurance for physicians, causing increase in health care costs.

Proposed Solution(s):
1) Legislation to cap malpractice lawsuits.
2) Provide physicians incentives to provide more pro bono medical care.
3) Medicare and other insurance companies should allow "monthly" deductibles to make amounts easier to pay.
4) If federal government provides funds for medical education, the federal government should make it a requirement for the physician to practice in a rural area for at least a year or two.
5) Federal government should provide incentives for physicians to provide care in rural areas (possibly tax breaks).
6) County or community should provide incentives for physicians to locate in rural communities (free or low cost housing, office space, etc.)

7) Clarify/simplify eligibility and enrollment information so people would readily understand what health care programs are available to them.
(8) Ensure fair, variable Medicare/Medicaid co-pay amounts, depending on income.

Priority Issue #2
Preventive Screening and Education.

Barriers:
1) Mobile units are available in some areas, but are under used.
2) Insufficient geriatric training for physicians/specialists, especially rural areas.
3) People don't always know they need to be screened and live a healthy lifestyle to prevent illness/diseases.
4) Insurance doesn't always pay for preventive care.
5) Not enough promotion of preventive care/health screening.
6) Lack of understanding by providers of ways to care for respond to older patients.

Proposed Solution(s):
1) Make full use of the mobile screening units that are available in the county; ensure they are staffed appropriately and ensure volunteers are readily available to assist.
2) Ensure there are ongoing and up-to-date training programs for providers of geriatric care.
3) Allow additional preventive screenings (covered by insurance) if referral is made by a doctor.
4) Educate physicians/providers in ways to care for/respond to seniors.
5) Medicare should pay 100% of an annual preventive screening for all people, not just the newcomers.

LOCATION OF EVENT: The Shepherd's Center – Sumter, SC

Priority Issue:
Affordable healthcare to include (medications, mental health, screening, vision, hearing, and dental).

Barriers:
1) Healthcare and health screenings are far too expensive for seniors and those with disabilities.
2) Lack of funding.
3) Lack of volunteers to assist with mobile screening units and other medical facilities.
4) Fraud by healthcare providers, pharmaceutical companies, and insurance companies.
5) Seniors need additional education on how to maintain a healthy lifestyle.
6) Healthcare providers need to be educated on how to appropriately communicate with senior patients.
7) Medical billing is too confusing to understand (errors or overcharges are hard to catch).

Proposed Solution(s):
1) Expand education program to providers and recipients.
2) Stop medication ads on TV.

3) Eliminate provider "pay-offs" by drug companies.
4) Use mobile screening units, especially in rural areas to ensure early diagnosis of problems.
5) Encourage more grass root contacts and involvement to help educate and assist seniors.
6) Ensure there are clear and simple instructions for medical billing and enrollment in various healthcare programs.
7) Fund additional research to eliminate or delay diseases and disabilities to lessen demand on medical treatment facilities and reduce recipient costs.
8) Increase the number of home health providers so seniors can age in place and decrease demand on institutions and medical treatment facilities.

Focus Group Concern: Shrinking number of geriatric providers even though the number of seniors are increasing because providers believe they don't get reimbursed sufficiently for Medicare/Medicaid clients.

LOCATION OF EVENT: Bethlehem United Methodist Church – Bishopville, SC

Priority Issue:
Access to health care including medications.

Barriers:
1) No health care available in Bishopville area after 5:00 pm weekdays and none on weekends.
2) Lack of money.
3) Lack of providers (specifically geriatric providers).
4) Lack of adequate transportation; what is available is not senior friendly.
5) Medication and medical programs too difficult to understand/access.
6) Medications too expensive.
7) Lack of specialty services to include therapy services.

Proposed Solution(s):
1) Fund/build a hospital in Bishopville (or at least fund an emergency care facility).
2) Provide incentives to attract providers to area by considering: tax breaks, housing, and pay for medical education.
3) Provide all required services to include specialties.
4) Review medical spending priorities at county and state levels.
5) Go to foreign countries to get cheaper medications if needed (creates competition).
6) Create an inexpensive, dependable, and senior friendly transportation system.
7) Prohibit campaign donations by drug companies.
8) Simplify all medical program enrollment forms.

Focus Group Concern: (1) Need for preventive health education programs, (2) Increased research needed to eliminate or reduce diseases and disabilities, and (3) Respect for age.

SOUTH CAROLINA
WHITE HOSUE CONFERENCE ON AGING

April 25-27, 2005

(F)
Long Term Care and Continuum of Care

Issue Papers

Carolina C

Long Term Care and Consumer Choice

By

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LONG TERM CARE AND CONSUMER CHOICE

Issue/Problem: Creating a system of long term care services that supports the values and preferences of older adults and their families

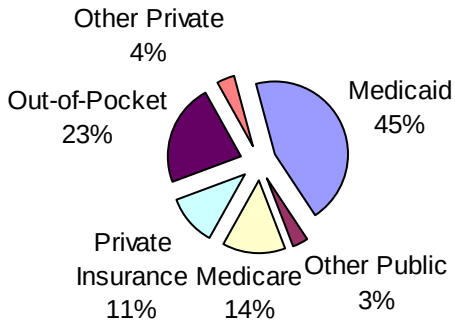
Background: Many older adults and other persons with disabilities require assistance with activities of daily living and/or chronic health needs. Long term care refers to the health and social support services needed to help some people function in everyday life. Such assistance makes it possible for them to maintain some independence and live in their communities. The type and degree of assistance required varies widely. It may include assistance with personal care (e.g., bathing, feeding, dressing), assistance with meal preparation and other household chores, help with mobility and finances, medical supplies, equipment, medication, or skilled nursing care.

Issues related to long term care increase in importance with the growth of the senior population. The 2004 AARP report, *Across the States: Profiles of Long-Term Care*, reports that 22.2% of South Carolina's 65 and over population has self-care or mobility limitations. The rapid growth in the 85+ population raises serious issues regarding the availability of long term care and how it is provided in the state. Consumer research in South Carolina, as in many other states, indicates that consumers wish to have more choice in how they receive services.

Barriers: The current system has significant barriers to consumers getting long term care services that are consistent with their values of: 1) receiving services at home and in the community, rather than in institutional settings; and 2) having control over how services are provided and who provides them.

The system that currently provides long term care is shaped by two powerful forces:

1) How care is financed – Most long term care expenses are not paid directly by the consumer, but are paid on behalf of the consumer by third parties such as government programs or insurance companies. While acting "on behalf" of the consumer, these third party payers have their own financial interests at stake and may impose rules and restrictions to protect those interests. Public funding pays for approximately 62% of long term care with the remainder covered by out-of-pocket expenditures, private insurance or other sources. The chart below shows the sources of funding for long term care.



Source: Kassner, Enic. *Medicaid and Long-Term Services and Supports for Older People.* AARP. 2004

Medicaid - As shown in the chart above, Medicaid is the largest payer of long term care. The Medicaid program must pay for skilled nursing home care and home health services (skilled nursing) for eligible persons age 21 and over. States may cover other optional long term care services such as personal care through the regular Medicaid program and may also cover special services or populations through Medicaid waivers. Waivers usually are only approved if they save the federal government money. In South Carolina, the waiver program for the elderly and disabled is known as the Community Long Term Care Program. It provides Medicaid-eligible clients who meet nursing home level of care with services such as personal care, home delivered meals, adult day health, attendant care and other support services. There is growing concern that states will be unable to support the growing costs of the Medicaid program, perhaps jeopardizing the long term care it finances as well as other health care services.

Medicare - Medicare generally doesn't pay for long-term care**.** Medicare doesn't pay for help with activities of daily living or other care that most people can do themselves. Some examples of activities of daily living include eating, bathing, dressing, and using the bathroom. Medicare pays only for medically necessary skilled nursing facility (SNF) or home health care, generally only for a short time after a hospitalization. Skilled care is health care given when skilled nursing or rehabilitation staff is needed to manage, observe, and evaluate the patient's care. Examples of skilled care are changing sterile dressings and physical therapy.

2) Who provides the care – Payers control who may be reimbursed for providing long term care services. Despite the fact that approximately 80% of all long term care is provided informally by families and friends, they typically are not eligible for reimbursement through public funding sources such as Medicaid and Medicare. Based on a traditional "medical model" of long term care, most payers have concentrated their resources on care provided by institutions and by professionals licensed by the state. So while consumers prefer care provided in their home and support services provided by family, friends, or other persons of their choosing, care must often be provided in "facilities" and even home care must be provided by licensed or certified professionals. These professionals influence or control the type, amount, location, and provider of services received.

South Carolina FY 2003 Medicaid expenditures for long term care for the elderly reflects that over 80% of expenditures went to provide institutional care.

SERVICE	PERSONS SERVED	FY 2003 EXPENDITURES	% OF LTC EXPENDITURES
Nursing Home Services	17,264	$418,568,552	83%
Home/Community Based Waiver - Elderly/Disabled	13,589	$73,834,320	15%
Home Health	7,765	$12,191,153	2%
TOTAL	38,618	$504,594,025	100%

Source: Burwell, Brian; Sredi, Kate; and Eiken, Steve. *Medicaid Long Term Care Expenditures – FY 2003.* Medstat. May 25, 2004. and SC DHHS Annual Report on Home and Community-Based Services Waiver (CMS 372 Report).

Note: Persons served are based on 11,522 Medicaid permit days for nursing homes; 11,000 approved slots for the waiver, and a limit of 75 visits per year per home health recipient.

Solutions to Overcome Barriers: To promote a system that provides for consumer choice and direction within the public sector, having the money "follow the person" is an approach advocated by the federal Centers for Medicare and Medicaid Services. States can allocate funding to support persons in need of long term care services, without narrow restrictions on the type, timing, location, and provider of services. Working within a limited budget based on the level of their disability, consumers (and families or other representatives if necessary) make the decisions about the kinds of services that will work most effectively for them, and the location, timing, and provider of those services. As consumers make changes in those decisions over time, the money budgeted for the person would follow them to the new services or providers.

South Carolina already has a Medicaid *Independence Plus* waiver under the President's New Freedom Initiative. Through this initiative, persons in the Medicaid Elderly/Disabled Waiver are offered the option of self-direction, with the assistance of a care advisor and a financial management service. It has been piloted in two regions of the state and is now ready to begin the process of being implemented statewide. Additionally, South Carolina's Family Caregiver Support Program operated statewide through the Lt. Governor's Office on Aging provides increased opportunities for caregivers to make care decisions.

Consumers who pay for their own long term care have the full array of choices about their care available to them (assuming services are available through the market place and at an affordable price). Therefore, decreasing dependence upon public financing is another way to promote individual control and choice.

Recommendations:

- ✓ Expand the concept of consumer choice to all public funding for long term care services. As part of this expansion, the state should no longer earmark long term care funds for certain services or providers, instead allowing those funds to "follow the person" to the service and provider of their choice. This would allow individuals and families to make decisions about their greatest needs and how they can be most efficiently and effectively met. This approach also recognizes the fluidity of needs of older adults and develops a payment structure that facilitates smooth transitions between service systems.

- ✓ Recognize that informal care is the backbone of the long term care system and must be supported by public policy. Support informal caregivers by providing a broader array of supports from which they can choose and by providing financial assistance to informal caregivers for providing care.

- ✓ Support federal legislation that will permit South Carolina and other states to implement a program that improves access to affordable private long term care insurance. Known as the Long-Term Care Partnership Program, the program permits consumers who exhaust benefits under their private long term care insurance to become eligible for services funded by Medicaid without having to meet the usual financial eligibility requirements. This enables consumers to avoid a spend-down of assets. The program is a win-win in that it saves the government money at the same time that it provides an incentive for consumers to purchase long term care insurance.

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Promoting a Continuum of Long Term Care Options

By

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Promoting a Continuum of Long Term Care Options

Issue: Promoting a continuum of long term care options

Background: Over the last 25 years, the availability of in-home care has become a viable option for elderly and disabled South Carolinians who need long term care services. Prior to this time, institutional (nursing facility) services were the major option for persons who needed assistance with their long term care needs.

The current service options are often referred to as a *continuum of care*, meaning the variety of long term care services that are available to consumers to help meet their needs. It is important to have as many choices as possible about the type and location of services that are provided. These choices may range from various home care options to out-of-home services in an assisted living or nursing facility. These choices reflect the needs and preferences of the person and also build on supports that are available.

Some major points for consideration include:

- Most persons prefer to remain in their own home and community for as long as possible and to receive the assistance they need in a home setting. The term "aging in place" has become an accepted description of being able to reside in the least restrictive setting for as long as possible.
- When home care is no longer an option, due to personal or financial circumstances or because of the unavailability of formal and/or informal supports, out-of-home services in an assisted living or nursing facility may become necessary.
- The demand for home care services has increased over the past 25 years. There are more services and providers of service available in both the public and private arenas. In addition, there are more funding sources for home and community based services
- Home care can be a cost effective alternative to institutional care, particularly for Medicaid, which is the major payer for long-term care services in our state.
- As demand has increased, emphasis has been placed on the quality of care and ways to assure the health, safety and welfare of consumers of long term care services. Because many of the consumers of long-term care services can be persons who are frail and vulnerable, there is increasing attention given toward ways to minimize the potential of abuse, neglect and exploitation.
- Just as home care options and services have evolved over the last decade, there are innovations and greater choices in assisted living and nursing home care.

Barriers and Possible Solutions:

In order to address the issues related to the long-term care in South Carolina and creating an adequate continuum of care, the following barriers should be addressed:

BARRIERS:	QUESTIONS TO CONSIDER:	RECOMMENDATIONS:
Increasing demand – The growth in our elderly population over the next five to ten years, will increase the demand for long term care services. Currently, there are 3500 persons awaiting assistance from the state's Community Long Term Care Program, a Medicaid-funded option for person with long term care needs. In addition, through the State's Aging Network it is estimated that over 3500 persons are awaiting home care services, such as home delivered meals.	• How can we develop incentives to build a strong network of long term care services in South Carolina? • How can we achieve a balance between publicly and privately funded service options? • What changes need to occur within the current continuum of care to accommodate increasing demand? • How do we balance the need for nursing facility care and home care?	✓ The State should develop comprehensive strategies to address the growing demand for long term care services.
Funding issues- As demand increases, there must be proposals to address the funding issues for long term care services.	• Can the State develop a stable source of revenue for long term care services? • How can we increase private contributions for long term care services and lessen the need for public financing? • What strategies do we need to use in developing these approaches?	✓ Both public and private funding strategies should be developed to address ways to finance long term care services for all South Carolinians.
***Education* – Both consumers and potential consumers and family caregivers need to be educated about long term care options so that they may plan for future years and select options that will best meet their needs and personal preferences.**	• How do we educate consumers and potential consumers of long term care about future needs and encourage pre-planning? • What are the most effective ways to provide this information?	✓ A comprehensive education campaign should be developed to address ways to educate consumers about long term care.
Addressing the role of caregivers - Research studies have suggested that over three-fourths of the care provided to older persons is from informal supports like family, neighbors and friends.	• What supports do we need to provide to caregivers? • How do we fund these programs and services? • What incentives can we offer caregivers, such as tax credits, to encourage their contributions?	✓ Strategies should be developed to reinforce informal caregiving and its value in the long term care continuum.

Community Residential Care

By

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March 24, 2005

RE: Issue Paper

Background:

SCARCH (SC Association of Residential Care Homes) is a non profit trade organization repre-senting assisted living/residential care in SC. As an Association, we represent over 250 commu-nities in SC ranging in size from 8 beds to over 100 beds. We represent communities that accept private pay and those that accept State pay. Our facilities range in all types from large campuses with independent, assisted and skilled components to small rural homelike residential communi-ties.

Assisted Living/Residential Care communities employ thousands of South Carolinians and pro-vide a level of service for residents between "can't live at home alone" to " maximum assistance with Daily Living. The advantage to Assisted Living/Residential Care is the cost and level of ser-vice they require or desire. The cost of assisted living is 1/2 to 2/3 that of skilled care and the resi-dent has as much or as little assistance as needed or desired in a more homelike setting.

Issue:

To fit assisted living/residential care into the continuum of long term care in SC and to raise the consumers' awareness of assisted living and make services available and affordable to all seniors.

This can only be accomplished with fair, concise community license regulations that are resident focused toward quality care and yet keep the services affordable.

There also must be a third party reimbursement system for low income seniors that pays the true cost of quality resident care and meets the increasing need for services. Government, both state and federal, must work with providers in a cooperative spirit to meet this ever growing need.

History:

As the long term care delivery system grew in SC, from the skilled communities and smaller "boarding home" residential care type facilities of the 1970's to less growth of skilled facilities and the tremendous growth of assisted living in the 90's, the face of long term care changed.

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Consumers looking for an alternative to skilled nursing flocked to true assisted living communities and as a result assisted living continued to grow 300% since 1995 to present day. Nationwide there are now almost twice the number of assisted living communities as there are skilled nursing facilities.

With this growth there became problems that must be addressed by Government and providers. The senior populations and their children now demand better services.

To meet this future, assisted living providers must:

Continue to educate the consumer on what is and is not considered assisted living and what services are appropriate for assisted living

Address "aging in place" and continue to work with other providers to transfer residents to proper level of care thus making the continuum of care work

Continue to work with State agencies to be sure regulations are clear, concise and not subject to varying interpretations, in addition to being resident focused.

To be sure that increased costs associated with regulations are addressed while maintaining an eye on keeping assisted living affordable

Continue to work with State agencies to make assisted living affordable to State sponsored residents, YET insure that this third party State sponsored reimbursement meets the true cost of quality care.

The above can only be accomplished if Government and all providers work together.

I see first hand how a continuum of care works as I have all three levels of care – and will be delighted to discuss in depth.

Thank you for the opportunity to share SCARCH's commitment to seniors.

Nikki Robertson

Nikki Robertson SCARCH Director of Large Facilities

The State Affiliate of the Assisted Living Federation of America

Long Term Care is an Integral Part of the Continuum of Care

By

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SC Health Care Association
Columbia, South Carolina

Issue paper
By: J. Randall Lee, President
South Carolina Health Care Association

ISSUE:
Long term care is an integral part of the continuum of care. It is not any more or less important than the other aspects of the continuum. Long Term Care has a longer history of providing care to the elderly but that in no way makes it the preferred method of delivery.

BARRIER
Unfortunately many feel the need to begin the discussion about the continuum through negative comments about institutional care. They fail to recognize that each component of the continuum is necessary in order to meet the needs of the individual. What we have done, either by choice or chance, is work our way backwards. Instead of assessing the needs of the individual at a time when they are healthy and prudent decisions can be made, we inevitably wait until a crisis is near or present and then are limited in our choices because of previous housing, financial or medical decisions.

SOLUTION
In my opinion, we have, as a State, not done a very good job of providing workable, affordable alternatives. At some point we decided that in-home services were a preferred alternative to institutional care. In reality this was always the preferred method and from the beginning of time until the present these services were provided by the families.

RECOMMENDATION
In order to develop a continuum of care, we must do a complete inventory of our current services with an accurate apples-to-apples cost analysis of each component. What I believe we will find is that the necessary services are not in place and that each component is expensive. Only once the problems and costs are identified can we move forward and develop a plan for the future. This assessment needs to include all stakeholders. A plan developed by bureaucrats and imposed on recipients and providers will not foster the ownership that is vital to success.

Community Forums Report

(F)
Long Term Care and Continuum of Care

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

LONG TERM CARE & CONTINUUM OF CARE

LOCATION OF EVENT: Fennell Elementary School – Yemassee, SC

Priority Issue:
Balance of institutional long term care and home/community based care based upon choice; home and community-based care following hospital stays.

Barriers:
1) Adequate financial support not readily available to frail seniors and their caregivers.
2) Energy relief resources complicated and information not readily available to the public.
3) Hospital discharges based on Medicare guidelines, not on patient's readiness for discharge; necessitating nursing home admittance rather than being cared for at home.
4) Hospital care managers and social workers do not adequately advise patients and their families of available resources/support; do not provide adequate education on how to care for patient upon discharge.

Proposed Solution(s):
1) Accelerate efforts to implement Consumer Choice Program (SC Choice) being piloted in some areas of South Carolina; financial relief for caregivers through tax breaks.
2) Increase funding for energy relief programs to help seniors access services.
3) Review Medicare/Medicaid guidelines to allow patients extended stays in hospital when healing time is slower or w hen more time is needed to allow patients to be able to return to home rather than move to nursing facility – sometimes just a few additional days would allow a smoother transition to home from a hospital stay.
4) Educate and better monitor efforts for hospital discharge planners to provide patients with adequate information on available resources and choices; better training of family members who will be providing home care for home bound seniors.
5) Review and elevate guidelines for Medicaid to better meet needs of broader senior population living on the upper edge of poverty but still without resources to meet basic living needs.

LOCATION OF EVENT: Gaillard Municipal Auditorium – Charleston, SC

Priority Issue:
The system for long term care (LTC) and a continuum of supportive care is inadequate to meet the needs of the growing older adult population.

Barriers:

1) High cost of long term care and medications.
2) Multiple entry points into the long term care system.
3) Lack of consumer knowledge of entry points and available services.
4) Complicated Medicaid eligibility requirements for both the consumer applicant and the facility applicant.
5) Lack of choices in rural areas.

Proposed Solution(s):

1) Improve the environment for workers in the institutional setting.
2) Increase the pay, supervision, and recognition of workers in home care programs and LTC facilities.
3) Encourage financial planning for the future.
4) Educate the public about the entry points, costs, and availability of services.

Recommendation:

Prioritize public funds so that adequate public resources are available to pay for the Long Term Care of our aging population. There should be an adequate quantity of home care, nursing homes, and assisted living facilities so that consumers have choices, including rural areas. Consumers should also have available affordable medications to prevent further deterioration of their physical and mental status.

LOCATION OF EVENT: Capital Senior Center – Columbia, SC

Priority Issue:

Need for pre-planning; need for faith community and family involvement; need for greater collaboration; need for better case management (3-4 services utilized per person).

Barriers:

1) Low income seniors have trouble with SC ACCESS (a state unit on aging Internet based information and referral system.
2) Difficulty in getting coverage for the middle income seniors- not rich enough – not poor enough.
3) Data base that Optional State Supplement (OSS) State Medicaid/Community Residential Care Facilities (CRCF) maintain.

Proposed Solution(s):

1) An increase in allocations in the Older Americans Act – specifically for direct services for in-home community based services, in order that seniors may reside in their homes longer and not rely on facilities. The savings are immense and people are happier.
2) The development of a continuum of care for case management in order to prevent duplication of services.

3) Given the proposed decrease in Medicaid funding for long term care, there should be public awareness/public education related to planning and choices related to long term care.

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
Cost of nursing homes and community care; availability of nursing home and community care; lack of resources for assistance for those needing less than skilled care; Lack of education on nursing home and community services placement and cost; pre-planning for cost.

Barriers:
1) Rural area, distance is great, not enough providers
2) How to pay for care, education of providing care, lack of family involvement;
3) Reluctance to receive assistance, resistance to outside help, culture;
4) No one available to give guidance.

Proposed Solution(s):
1) Tax break to keep a person at home.
2) Family leave from job.
3) Use congregational nurses as volunteers.
4) Free commercial spots for senior services.
5) Directory in phone book of senior services.
6) Congregational nurses to help supplement family members caring for seniors.
7) More affordable providers.

LOCATION OF EVENT: Pinckney Hall, Sun City Hilton Head – Bluffton, SC

Priority Issue:
Institutional care with home and community-based care based on choice; home and community based care following hospital stays.

Barriers:
1) Consumer has no choice in how funds are spent for long term care or nursing home care.
2) Not enough nursing home beds, nor residential hospice care beds.
3) Caregivers do not receive enough assistance when they choose to keep their frail senior family member at home rather than in a nursing home.
4) Family members and senior patients not fully informed of their options, nor properly trained in caring for the ill loved one prior to hospital discharge.
5) Home health care beyond most budgets of middle income seniors, yet, this is the preferred means of caring for them.

Proposed Solution(s):

1) Implement SC Choice throughout South Carolina to assist family in caring for loved ones at home; make available to low and middle income seniors.
2) Review and revise regulations of number of beds in a regions for nursing home level of care and for residential hospice care; especially rural areas.
3) Assist caregivers financially when they have to quit a job to care for elderly parents so that they can care for their parents at home rather than in a nursing home if that is their choice.
4) Provide more aggressive training to medical professionals on services available to seniors as well as require proper training for care by family members before discharge from hospitals.

LOCATION OF EVENT: H. Odell Weeks Activity Center – Aiken, SC

Priority Issue:

Long term care (LTC) and a continuum of supportive services is inadequate to meet the needs of the growing older adult population.

Barriers:

1) High cost of long-term care and medications.
2) Confusion on Medicare Reform and the Medicare Part D card.
3) Complicated Medicaid eligibility criteria for the applicant.
4) Lack of choices in rural areas.
5) Employers are terminating and/or changing health insurance for retirees that they have counted on while making future plans. This will create problems as a result, if not stopped.

Proposed Solution(s):

1) Increase the recognition of workers in home care programs and LTC facilities.
2) Educate the public about costs, services, and entry points for LTC.
3) Encourage financial planning for the future.
4) Insurance companies should not be allowed to discriminate against retirees.

Recommendation:

There should be an adequate choice of home and community based services, assisted living facilities, and nursing homes so that consumers have choices, including the rural areas. Consumers should have access to affordable medications to prevent deterioration of their physical and mental conditions. Companies should not be allowed to change or terminate insurance plans for retirees.

LOCATION OF EVENT: Orangeburg County Council on Aging –Orangeburg, SC

Priority Issue:
Long term care (LTC) and a continuum of supportive services is inadequate to meet the needs of the growing older adult population.

Barriers:
1) High cost of long-term care and medications.
2) Complicated Medicaid eligibility criteria for the applicant.
3) Many seniors are afraid of the Estate Recovery Law and refuse services under Medicaid.
4) Lack of choices in rural areas.

Proposed Solution(s):
1) Increase the recognition of workers in home care programs and LTC facilities.
2) Educate the public about costs, services and entry points for LTC.
3) Education programs about the Estate Recovery Law.
4) Encourage financial planning for the future.

Recommendation:
There should be an adequate choice of home and community based services, assisted living facilities and nursing homes so that consumers have choices, including the rural areas. Consumers should have access to affordable medications to prevent deterioration of their physical and mental conditions.

LOCATION OF EVENT: City Council Chambers – Rock Hill, SC

Priority Issue:
Long-term care living.

Barriers:
1) The cost of providing long-term care is cost prohibitive especially acute care.
2) A cost of $3,000 to $5,000 monthly is not affordable for most.
3) Medicaid facilities for this type care not available.
4) Need to find more affordable long-term care facilities.
5) A big gap exists between Medicaid and t he minimum $3,000 funding needed to cover long-term care costs.
6) The average age of participants at senior centers is increasing.

Proposed Solution(s):
1) We all want seniors to have a good quality of life and to remain at home. We need to identify ways of allowing seniors to remain at home.
2) We need to identify ways of getting seniors not to remain permanently in the nursing home but to return to their own home as soon as feasible.

3) Increase the availability of acute care.
4) Very small percentage senior population actually in nursing homes.
5) Movement to redirect funding from nursing homes to supporting seniors who remain in t heir homes. Need to support this idea more to counter the medical model.

LOCATION OF EVENT: Santee-Lynches Regional Council of Governments – Sumter, SC

Priority Issue:
Safe, affordable neighborhoods/communities for living independently.

Barriers:
1) Lack of available land opportunities.
2) Lack of central location.
3) Lack of available transportation
4) Too much emphasis on contractor profit.
5) Building codes too restrictive.
6) Many available living areas are not safe.

Proposed Solution(s):
1) Plan and build safe, friendly neighborhoods so seniors can live independently.
2) Establish reliable transportation.
3) Provide a safe/secure environment by: using cameras, hiring additional police personnel, establishing an active neighborhood watch program, using gated area entrances, ensuring safe and lighted walkways/sidewalks, and using single story dwellings.

LOCATION OF EVENT: Emmanuel Baptist Church – Manning, SC

Priority Issue:
In-Home Services.

Barriers:
1) Lack of available services to ensure seniors can remain in their own homes.
2) Lack of affordable medical services.
3) Lack of affordable medications.
4) Lack of services to provide leg braces, wheelchairs, hearing aids, glasses, diabetic shoes, and other items not traditionally provided by Medicare.

Proposed Solution(s):
1) Provide more affordable and reliable in-home services to assist clients with activities of daily living (ADLs) (morning in-home services more senior friendly, extend existing in-home hours each day, and extend services to include weekends, too.)
2) Provide affordable medical health care to include medications.

3) Allow Medicare to pay for items that are necessary to improve quality of life.

Focus Group Concern: (1) Housing (rehab, modification, and low-income quality homes needed); and (2) Alzheimer's (more Alzheimer's income services needed and more Alzheimer's education needed, especially in rural areas.)

LOCATION OF EVENT: Kershaw County Health Resource Center – Camden, SC

Priority Issue #1:
Lack of appropriate placement for those requiring adult day facilities, assisted living facilities, and in-home care.

Barriers:
1) Inadequate reimbursement rate for Assisted Living Facilities.
2) Federal policy for funding.
3) Education.
4) Lawsuits.
5) Lack of pharmacies in smaller towns and rural areas.

Proposed Solution(s):
1) Increase funding, then consider centralization of money for case management.
2) Provide additional community education resources.
3) Expand Medicare/Medicaid coverage.
4) Tort reform.
5) Create incentives for drug companies to establish pharmacies in rural areas.

Priority Issue #2:
Lack of geriatric and specialization of physicians.

Barriers:
1) Lawsuits.
2) Education.
3) Absence of pharmaceuticals in rural areas.

Proposed Solution(s):
1) Tort Reform.
2) Funding for pharmacies.

Priority Issue #3:
Lack of specialized services for seniors, especially for those who require mental health and Alzheimer's services.

Barriers:

1) Availability of professional care providers (psychiatrists, gerontologists).
2) Availability of resources/funding.
3) Lack of specialized facilities.
4) Lack of education.

Proposed Solution(s):

1) Increase funding to provide additional specialized services and to improve education resources.
2) Expand Medicare/Medicaid to cover these services.
3) Build adequate facilities.

LOCATION OF EVENT: The Shepherd's Center – Sumter, SC

Priority Issue:

In-home long-term care (skilled and routine, as needed).

Barriers:

1) Not enough providers and caregivers.
2) Lack of continuity.
3) Lack of medical care.
4) Insurance companies do not cover in-home long-term care.
5) So many different levels of service needed for seniors to remain in their homes, all dependent on recipient's health, age and needed skills.

Proposed Solution(s):

1) Train more providers and caregivers.
2) Encourage and provide incentives for physicians to make house calls.
3) Help families prepare for having back-up systems to care for the recipient in case the primary caregiver is not available.
4) Revise insurance coverage to include in-home long-term care

Focus Group Concern: (1) Long-term care facilities are not affordable; and (2) Long-term care facilities need to be more senior friendly.

LOCATION OF EVENT: Bethlehem United Methodist Church – Bishopville, SC

Priority Issue #1:

Quality of long-term care facilities.

Barriers:

1) Inadequate monitoring of long-term care facilities.

2) Inadequate number of staff.
3) Inadequate number of trained staff.
4) Overcrowding now, but will become worse due to growing number of senior population.
5) Obvious level of service and a very different environment for paying clients and Medicaid/Medicare clients (noticeable separation).

Proposed Solution(s):
1) Build more affordable facilities.
2) Ensure sufficient specialized facilities (Alzheimer's, Mental Health).
3) Review current operating procedures of existing long-term care facilities to ensure they are more efficient and effective in caring for seniors and those with disabilities, regardless of paying status.

Priority Issue #2:
Not enough funding for long-term care facilities and to assist families.

Barriers:
1) Long-term care insurance too expensive.
2) Budget deficit prevents adding governmental funds to long-term care program.
3) Insufficient number of affordable long-term care facilities.
4) Often families cannot visit loved ones in long-term care facilities due to travel distances.

Proposed Solution(s):
1) Seek funding for long-term care program.
2) Encourage a healthier lifestyle so seniors can remain in their own homes longer.
3) Ensure there is accountability of funding and programs to ensure best use of available money.

Focus Group Concern: (1) Not enough caregivers, (2) Insufficient number of reliable caregivers, (3) Many affordable facilities are not stable or adequate, and (4) Need more public information on adult day care (cost and operation).

South Carolina
White House Conference on Aging

April 25-27, 2005

(G)
Caregiving

Issue Papers

Carolina B

Caregiving:
Addressing the Needs of Family Caregivers

By

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Waccamaw Regional Council of Governments
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CAREGIVING

Issue : Addressing the Needs of Family Caregivers

How do we, as a society, provide care for those aging citizens who are no longer able to function independently, now and in the future? Caregiving, which is one of the most personal of issues, has now become a major public concern. As the population ages, more Americans face the challenges of providing care to loved ones who need help. According to a recent National Long Term Care survey, over 7 million people are informal caregivers (spouses, adult children, other relatives and friends) to 4.2 million older persons with disabilities living in the community. Here in South Carolina there are over 390,000 family caregivers providing 419 million hours of care per year. (Arno, 2003)

Informal caregivers, family and friends, are the backbone of our long term care system. Family caregivers provide over 80% of all home care services. In fact, only about one-third of disabled elders use any formal (paid) home care. If the work of these informal caregivers had to be replaced by paid home care the cost would be $45 to $94 billion per year.

Most caregivers (63%) are helping the care recipient with four or more activities of daily living (bathing, dressing, toileting, transferring, eating) as well as instrumental activities of daily living (transportation, cooking and housework). (Johnson, 2001)

Research has found that 73% of caregivers provided care to a loved one for over 12 months. (Johnson, 2001) Family caregivers routinely underestimate the length of time they will be needed. Only 46% expected to be caregiving longer than two years, but the average length of time spent on caregiving is about eight years. (MetLife, 1999)

More than half of caregivers are balancing caregiving responsibilities and employment. The multiple responsibilities of the family caregiver produce a physical, psychological, emotional, social and financial "caregiver burden" which research indicates affects 50% of caregivers. Research has linked caregiver burden with caregiver illness and early placement of the care recipient into institutional long term care placement. (Johnson, 2001)

Suzanne Geffen Mintz, a family caregiver and president of the National Family Caregivers Association, has said, "As we become family caregivers, we add work to our already busy lives. Even though most of us very willingly and lovingly take on this added responsibility, we must remember that we are doing just that, adding more responsibility and more work."

The National Family Caregiver Support Program was established in 2000 with the enactment of the Older Americans Act Amendments. The program was developed by the Administration on

Aging and was modeled after already successful programs in several states and after listening to family caregivers themselves. The program calls for all states, working with area agencies on aging and local community service providers to have five basic services for family caregivers, including:

- Information to caregivers about available services;
- Assistance to caregivers in gaining access to services;
- Individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions and solving problems relating to their caregiving roles;
- Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
- Supplemental services, on a limited basis, to complement the care provided by caregivers.

How are we, as a society, going to provide care for those who need assistance and support for those who care for them during the next ten years, twenty years and into the future?

Barriers

Informal caregivers often go unnoticed except by those depending on them for care. Society as a whole--policymakers, clergy, media, and employers—does not recognize the importance of the family caregiver.

Adequate supportive services are often not available. A survey of caregivers found that caregivers have varying needs for support services. The mostly cited needs were counseling for the care recipient, in-home health care, and home delivered meals. This survey also records that finances frequently prevent care recipients from getting the services they need. Many services are not covered by insurance. The other barriers cited by these caregivers were the "hassle factor" (not having services available at time of need, not being able to get off work, etc.) and the lack of knowledge of how to get services. (Johnson, 2001)

The need for respite care was reported by 39% of caregivers but only 19% received it. Respite care is not usually covered by Medicare, Medicaid or private insurance. Research shows that caregivers with the highest incomes used more respite than others, perhaps indicating that cost of respite is a significant barrier. (Johnson, 2001)

The financial costs of caregiving create a barrier for caregivers. Caregiving families tend to have lower incomes than non-caregiving families. (NCFA, 2000) Research indicates that the out of pocket medical expenses for a family that has a disabled member who needs assistance with activities of daily living is more than 2.5% greater than a family without a disabled member.

(Cunningham, 1999) One study found that 61% of the estimated 2.5 million Americans who need assistive technology can't afford it. (Iezzoni, 2002) The cost of purchasing supportive services is another burden that often falls upon the family caregiver. Thirty eight percent of caregivers reported that they felt overwhelmed by the financial hardships caused by caregiving. (Johnson, 2001)

Solutions:

Informal caregivers need a wide range of support services to remain healthy, improve their caregiving skills and remain in their caregiving role. Caregiver support services must include information, assistance, counseling, respite, home modifications or assistive devices, support groups and family counseling. These support services can and do make a real difference in the day-to-day lives of caregivers.

Family caregivers can be empowered through a combination of information and education, problem solving, skill building, and support. These supportive services help families manage the complexities of their caregiving situations, increase competence and confidence in their caregiving role, and enhance their well-being.

Caregivers should have access to geriatric care coordinators who can bridge the gaps in services, assist in coordinating and supervising services, to support and enhance the caregiver's ability to continue to meet their care recipient's needs in the community.

Advocates for the elderly and disabled agree that, with proper patient-support services such as meal delivery and transportation to medical appointments, community-based care is a better option than nursing homes.

Recommendations:

Expansion of the Family Caregiver Support Program is needed to provide active, positive encouragement and support to family caregivers. The Family Caregiver Support Program in South Carolina provides trained advocates available to assist caregivers seeking help. Expansion of the program would allow for the addition of advocates as well as more financial support to family caregivers.

We must provide the funding necessary to ensure that medical and supportive services to their health and care are provided to the elderly. Adequate funding for home and community based services to meet the health needs of the elderly is vital. But we must also ensure that these services are consumer directed, quality oriented and monitored to provide the framework needed to ensure that our seniors age with grace and dignity.

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Respite and Support Groups

By

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April 26th panel, Respite -11am session

Linda Cello, Program Manager for the Alzheimer's Association Palmetto Chapter

Issue: The numbers of caregivers are ever increasing as a result of the "sandwich generation" and the elderly spouses who now find themselves caring for their loved ones. Caregivers are in great need of "down time" and help as they provide the main source of patient care. Many do not know what respite is all about. Where is the help for these individuals? What is respite and does respite really exist?

Today's caregivers are rarely included in the continuum of care of the patient. Many are not acknowledged for what the do; often times not even by other family members who cannot or will not see the amount of work, frustration, anger, or selflessness that is required. Few recognize the stress that is placed on them. Caregivers are often lonely, isolated, and in need of someone to give to them. They are often loving, sometimes patient, gentle, tired, giving and many have had to become caregivers, although they never pictured themselves in this role.

Barriers:

Caregivers are a tough bunch. They are often guilt-ridden and they almost always declare that "No one can provide the quality of care that I can. I promised my mom that I would always take care of her." They are reluctant to ask for help. When they do, they often turn to family to help with the responsibilities and costs. Not all family members are willing to step up to the plate resulting in additional stress on the caregiver who thought they could count on family. There is often a lack of education about the illness or disease or respite itself. The good news is that respite does exist! The barrier is finding it, which may mean becoming creative. Respite is that break or downtime for the caregivers who desperately need time for themselves. Whether it is time to go out and grocery shop, walk on the beach or read a newspaper – it is a must so the caregiver can get a break and maintain a sense of self.

Many caregivers do not know that help may be available to them, and that there are several types of respite. They are often averse to talking about their own problems, always focusing on the patient. While their efforts are to be applauded, they must also realize that they cannot sacrifice their own health and relationships for total care-giving. It is important that they realize that they must care for themselves first to ensure that they will be healthy enough to provide care to the patient. It is now becoming clear that caregivers are placing themselves at risk for dying before the one they have been caring for.

As families spread out across the country, it may not always be feasible to count on loved ones to provide help in the care-giving process. Some may or may not be willing or able to send money to help. It becomes evident that caregivers must educate themselves, families, and friends about the illness or disease and how much stress it is placing on the individual.

Solutions:
Where does this elusive respite come from? Respite can mean 15 minutes for reading, stretching, a cup of tea, or walking. It can mean allowing a willing neighbor to stay for 2 hours so you can get out of the house and get a taste of "normal, everyday activities." Neighbors and friends may be overlooked as potential relief, but sometimes friends may not call as often as they once did. When was the last time someone asked you, "How are you doing? Can I help?" How often do you turn them down? The "I can do it all syndrome" is a reality.

Caregivers need to be aggressive in researching all avenues of respite. One of the problems is that many are unaware of where to look or who to call. Many do not avail themselves to hospice care. Respite funding sources may be available to provide financial assistance, but where are they?

It is important to know what resources are available in your area. Councils on Aging are great places to start. Research the illness or disease and call national associations for information on local chapters that may provide help. Contact your church. Many have respite programs or volunteers willing to help. Surf the web if you have access to it or ask someone to do it for you. Visit the local Senior Center. Ask your doctor.

Accept help from others. Hospice is for the living and may provide free help if you meet the criteria. Support groups provide a great outlet where caregivers can discuss their situations with others who are going through similar problems. They are great places for problem solving and to get sympathetic ears to listen to you and for caregivers to learn from each other.

Recommendations:
Education and involvement! Reach out and contact federal, state and local representatives and tell them how much caregivers need financial support to provide respite. Contact the Silver Haired legislature and the AARP to voice your concerns, increase awareness, and gather support. You can make a difference!

Know what opportunities are out there. The Older Americans Act Amendment of 2000 provided a new program called The National Family Caregiver Support Program. This program was implemented to address the needs of caregivers by offering assistance to gain access to supplemental resources and information, as well as respite care. Contact agencies like the VA, state Family Caregiver Support Programs, and national associations.

The caregivers must educate themselves, their families, friends, and legislature. They must discuss their needs and stress levels. It is important to be proactive in seeking sources of increased respite funding.

Workplace Issues:
Employees and their Elderly Parents

By

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ISSUE PAPER-SC WHITE HOUSE ON AGING
APRIL 25-27, 2005 MYRTLE BEACH, SC

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PANELIST

STATEMENT OF THE ISSUE

Managing the care of aging parents or a disabled family member while trying to meet work and family responsibilities is a challenge that faces a rapidly growing segment of our work population. The Share The Care program, developed by Care For Life, Inc. is a workplace benefit for managing care for employees with elderly dependents.

As a result of increasing elder care responsibilities in the U.S. workplace, the U.S. Department of Labor Women's Bureau found that 29% of working caregivers had to rearrange work schedules, 21% reduced work hours, 19% to time off without pay, and 9% of the employee had to quit work to become a full time caregiver. The Bureau of National Affairs reported employer costs and problems related to eldercare, which include absenteeism, tardiness, visible signs of stress, excessive phone calls, requests for reduced hours, turnover, health problems, decreased quality of work and increased work accidents.

The impact of eldercare on employees and employers falls into five categories:

1. Replacement costs for employees who leave due to their caregiving responsibilities.
2. Increased use of sick leave and FMLA to care for an aging parent.
3. Costs due to work interruptions while the employee contacts doctors, home health aides and other paid workers.
4. Expenses and time spent supervising employed caregivers.
5. Lower productivity due to high rate of stress related disorders among working caregivers.

BARRIERS TO OVERCOME IN ORDER TO ACT ON THE ISSUE

Demographic Background Of Workers
Gender
Household Employment
Form Of Care
Living Arrangements

SOLUTIONS

Assessment Of Existing Dependent Care Benefits
Leave Of Absence Options
Flexible Spending Account Options
Geriatric Care Management Employee Assistance Programs
Long-term Care Insurance

RECOMMENDATIONS FOR ACTION

Needs Assessment Survey
All Employees Participate In The Process Of Program Development
Plan To Have Assistance Available For Fmployees With Needs In The Near Future
Allocate Resources For Communication and Training
Develop Organizational Philosophy For Programs To Manage Work and Family Integration

Community Forums Report

(G)
Caregiving

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

CAREGIVING

LOCATION OF EVENT: Florence Civic Center – Florence, SC

Priority Issues:

Q) Need to support caregivers
R) Incentives to encourage family members to care for aging relatives
S) Caregiver support: training, respite, information, referral, needs assessment and financial support for family caregivers
T) Training and financial support for paid caregivers
U) Grandparents raising grandchildren.

Proposed Solution(s):

O) Recommend providing more flexibility in the delivery of services and reimbursing non-traditional service providers (e.g., friends, relatives, and neighbors). Seniors and their family members should not be limited to the type of service provider with whom they may contract for services.
P) Recommend developing more varied home and community based services, including information and transportation, to enable seniors to maintain their independence and dignity.
Q) To serve more clients and to offer more services to these individuals, additional FCSP funds are desperately needed. We recommend a significant increase in funding for the FCSP.
R) Recommend supervision from Social Service agencies to ensure persons are not being abused or neglected in the home environment.
S) Increase public awareness of the Family Caregiver Support Program.
T) Increase public awareness of Family Caregiver Support Groups.

LOCATION OF EVENT: Gaillard Municipal Auditorium – Charleston, SC

Priority Issue:

Unpaid caregivers are faced with financial challenges, a decline in their spiritual, emotional, and physical health, and lack the necessary training and support to keep care recipients in the home.

Barriers:

1) Inability to work outside of the home and provide full time care.
2) Lack of resources to pay for respite care, personal care, personal care items, and Medication.

3) Injuries in the home.

Proposed Solution(s):

1) Provide increased training to caregivers on financial management, proper techniques, and stress reduction.
2) Encourage private companies to provide on-site adult day programs.
3) Provide more community-based funded respite.
4) Encourage companies to provide family leave for caregivers
5) Use lottery dollars to fund programs for older adults.
6) Provide a monthly stipend to caregivers.
7) Tax incentives for private companies donating funds to assist with caregiver services.

Recommendation:

To create more funding sources for senior caregiver services including more community-based programs for in-home care, caregiver training, respite, supplies, medication, and volunteer respite workers. Actively pursue and implement public, private and faith based partnerships, including tax credits and incentives for corporate participants and family caregivers.

LOCATION OF EVENT: Capital Senior Center – Columbia, SC

Priority Issue:

Lack of coordinated information and referral point; lack of case management; lack of services; lack of health insurance for working caregivers; lack of reward for thrifty seniors; hospital discharge planning is inadequate; long range impact on current caregivers that has future repercussions.

Barriers:

1) Cost;
2) Employer attitudes;
3) Status and pay scale of service providers;
4) Convenience of service to family;
5) Lack of truly knowledgeable information and referral staff;
6) Support groups should meet at convenient time and provide respite at the same location;
7) Lack of health information for family caregivers who would work part-time.

Proposed Solution(s):

1) Increase services for family caregivers in the areas of home modification, medication assistance, in-home supports such as personal care aides and respite providers.
2) Help working family caregivers by giving incentives to employers for family friendly policies and by changing health insurance policies so part-time workers can access it.

3) Strengthen information and referral function of AAA, improve education of caregivers; add case management for family caregivers or provide tax credits.

LOCATION OF EVENT: H. Odell Weeks Activity Center – Aiken, SC

Priority Issue:
Unpaid family caregivers are faced with financial challenges and t heir own life is "put on hold."

Barriers:
1) Lack of resources to pay for respite care, personal care, etc.
2) Inability to work outside of the home and continue to provide full time care for a loved one.
3) Lack of trained workers for in-home services such as respite care, personal care, etc.
4) Lack of Adult Day Care services.

Proposed Solution(s):
1) Provide increased training and support for caregivers.
2) Encourage agencies and/or private companies to provide adult day services.
3) Provide more community based funded respite programs.
4) Provide tax incentives for caregivers.
5) Provide training for unemployed persons to work in the health care field.

Recommendation:
To create more funding sources for senior services including more home/community based programs for in-home care.

LOCATION OF EVENT: Orangeburg County Council on Aging-Orangeburg, SC

Priority Issue:
Unpaid family caregivers are faced with financial challenges and their own life is "put on hold."

Barriers:
1) Lack of resources to pay for respite care, personal care, etc.
2) Inability to work outside of the home and continue to provide full time care for a loved one.
3) Lack of trained workers for in-home services such as respite care, personal care, etc.
4) Lack of adult day care services.

Proposed Solution(s):
1) Proposed increased training and support for caregivers.
2) Encourage agencies and/or private companies to provide adult day care services.
3) Provide more community based funded respite programs.
4) Provide tax incentives for caregivers.

Recommendation:
To create more funding sources for senior services including more home/community based programs for in-home care.

LOCATION OF EVENT: City Council Chambers – Rock Hill, SC

Priority Issue:
Caregiving is very important and must be widely supported.

Barriers:
1) Increased need for respite care but there is not adequate funding.
2) Increasing number of grandparents caring for grandchildren. Seniors need help caring for grandchildren.

Proposed Solution(s):
1. Establishing geriatrics best practices. This is being considered by the Southern Baptist Association.
2. Movement by the faith community to help.
3. Better care for residents is provided when they are able to remain in their home.
4. Volunteer programs would be helpful in increasing the awareness of seniors and their needs.
5. Telephone reassurance programs were beneficial before they lost their funding for staying in touch with seniors.

LOCATION OF EVENT: Santee-Lynches Regional Council of Governments – Sumter, SC

Priority Issue:
Age criteria.

Barriers:
Caregiving Program guidelines state program eligibility age is 60 and above.

Proposed Solution(s):
Restructure Older Americans Act to include people age 50 and above.

LOCATION OF EVENT: Emmanuel Baptist Church – Manning, SC

Priority Issue #1:
Financial assistance to family and non-family caregivers.

Barriers:
1) Federal government policies program funding restrictions; program restrictions.
2) Not enough money being utilized properly; mediators are not available to assess client needs (financially, etc.).

Proposed Solution(s):
1) Review government policies to ensure they are fair and adequate.
2) Increase funding and/or use appropriately.
3) More accountability with program and finances.
4) Base services provided on individual need, not group need.

Priority Issue #2:
Availability of a 24-hour caregiver.

Barriers:
1) Lack of funding.
2) Insufficient number of caregivers available to provide adequate coverage.
3) Lack of training.
4) Family members having insufficient time to devote to recipient.
5) Labor laws.

Proposed Solution(s):
1) More funding through other programs.
2) Improve communications to ensure families are aware of availability of caregivers.
3) Provide training to family and non-family caregivers.
4) Save money and to increase care, hire caregivers in nursing homes to relieve nurses.

LOCATION OF EVENT: Kershaw County Health Resource Center – Camden, SC

Priority Issue #1:
Funding for caregiving services.

Barriers:
1) Program has a lack of funding priority.
2) No tax breaks for caregivers.

Proposed Solution:
1) Obtain additional funding for program, to include private funding.
2) Rearrangement of priority funding.
3) Restructure tax code to provide tax breaks for caregivers.
4) Encourage long range family planning for future caregiver needs.

Priority Issue #2:

Training for caregivers.

Barriers:
1) All family members are not involved in the care of recipient (abandonment of family, needs to be a partnership).
2) Availability of caregiver to attend training due to lack of spare time – too busy taking care of the recipient.
3) Lack of transportation to attend training.
4) No funding available to provide adequate training to caregivers.
5) No "train the trainer" courses available in the current caregiving program.
6) Lack of specialized caregiver training, especially Alzheimer's training.

Proposed Solution(s):
1) Take training classes into the home.
2) Fund so adequate training can be provided.
3) Recruit more trainers.
4) Ensure adequate respite care is given to the caregivers so they can attend training and receive rest and relaxation.

Priority Issue #3:
Respite

Barriers:
1) Insufficient number of respite relief workers.
2) Inadequate funding available to fulfill respite needs.
3) Inadequate number of facilities that provide care while caregiver is in respite.
4) Care facilities/services too costly.
5) Caregivers have inadequate medical training.

Proposed Solution(s):
1) Medicare and Medicaid should be changed to allow funding for respite.
2) Train other family members to provide assistance to ensure primary caregiver has sufficient respite.
3) Seek out trained volunteer caregivers.
4) Establish affordable private care so primary caregiver can have sufficient respite.

Focus Group Concern: Lack of caregiving oversight due to care being provided in-home, occurrence of diverse situations, vastness of caregiver responsibilities, and privacy/autonomy requirements.

LOCATION OF EVENT: The Shepherd's Center – Sumter, SC

Priority Issue:

The education of caregivers.

Barriers:
1) Inability to access training sessions.
2) Insufficient marketing of existing programs and services.
3) Lack of trainers.

Proposed Solution(s):
1) Provide in-home training.
2) Establish a volunteer respite worker program to free up caregivers.
3) Increase the number of caregiver support groups.
4) Increase knowledge level of buddy call program.

LOCATION OF EVENT: Bethlehem United Methodist Church – Bishopville, SC

Priority Issue:
Care recipient income not sufficient to cover high costs of in-home care.

Barriers:
1) Medicaid's income eligibility requirement (to qualify for Medicaid) is too restrictive. Annual limit is currently $4,000 and under.
2) Eligibility age to qualify for the Caregiver Program is too high (currently 60+).
3) Cost of healthcare service, healthcare providers, and caregivers too high.

Proposed Solution(s):
1) Provide training to seniors who wish to be caregivers at little or no cost – a "win, win" for both parties (would provide much needed work for seniors; these caregivers could provide more affordable assistance to recipients than what is currently available from existing agencies.
2) Increase level of personal income to receive Medicaid.
3) Make available affordable health care services, providers and caregivers, publish a list of available affordable caregivers that have received training.
4) Lower age qualification for family caregiving program assistance and health care assistance.
5) Increase funding.
6) Promote volunteerism.

Focus Group Concern: Lack of funding for caregiver relief.

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
Health care concerns, including sitter services to help with caregiving; services to help grandparents who are raising grandchildren.

Barriers:

1) Trust.
2) Personal finances.
3) Information overflow or not enough information.
4) Communication.
5) Lack of resources

Proposed Solution(s):

1) Provide information to local churches and doctors to dispense information on services.
2) Use community festivals to get information out about available services.

South Carolina
White House Conference on Aging

April 25-27, 2005

(H)
Research

Issue Papers

Carolina D

Creating Seamless Transitions While Improving EOL Care Across All Settings

By

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PACT Categories: Continuum of Care and Research

Creating Seamless Transitions While Improving EOL Care Across All Settings

Issue/Problem

The Institute of Medicine in their most recent report (2003), *Describing Death in America: What We Need to Know,* note the need for better information that goes beyond demographics and health conditions to issues that include quality of life for patients and their families and continuity of care during the last year of life..."the experience of dying." Teno, et al. (2004) have identified five domains for measurement of quality, one of which is coordination of care across settings. The Rand Health Acove Project (2001), *Developing Quality of Care Indicators for the Vulnerable Elderly* published in 2004 its quality indicators for continuity and coordination of care in vulnerable adults, but as yet these have not been widely disseminated, nor used to evaluate the current state of care. However, a report published in 2003 by *Last Acts*, an initiative of the Robert Wood Johnson Foundation, indicates that South Carolina ranks among the worst states on previously identified indicators of quality EOL care (advance directive laws, number of deaths in the hospital vs at home, number of ICU days, hospitals reporting hospice/palliative care programs, referrals to hospice, and professionals certified in palliative care, among others).

Previous studies have documented one or more transitions in care settings the last six months, and even the last 30 days of life among the frail elderly (Cooney, et al., 2001, Tolle, et al., 2000, Craig, 2002, and Lewis, Cretin, and Kane, 1985). Numbers of transfers between care settings, in part a function of fragmented reimbursement systems and uncertainty about death, vary in these studies from one to six during the last 30 days of life alone.

Fiscal Impact

Studies by CMS and others document the fact that costs the last year of life are substantially higher than at any other time. In fact, 30% of Medicare expenditures are spent on the 5% of Medicare recipients that die each year (Barnato, et al. (2004). Literature also documents regional variations in end-of-life care patterns. Better quality outcomes are not correlated with greater use of hospital stays, use of intensive care and aggressive treatments, and use of more physician specialty visits (Wennberg, 2000, Hanson, Tolle, and Martin, 2002). The Southeast, and specifically South Carolina, is among those regions of the US that rely more heavily on high cost hospital and other aggressive medical services. Strategies that address both provider patterns of care as well as coordination, communication, and continuity for vulnerable frail seniors very probably would have significant cost avoidance implications.

Barriers

Fins, et al. (2003) identify significant financial and regulatory disincentives, as well as non-financial barriers to the delivery of seamless end-of-life care. Among the non-financial barriers identified are: 1) conflicting goals among hospitals, nursing facilities, and hospice, 2) portability of patient data across care settings, 3) the absence of coordination across venues of care, and 4) interdisciplinary communication within a single setting and across settings. A fifth non-financial barrier underlying failures to coordinate and communicate across venues may, in fact, be a lack of role clarity and clear specification and assignment of responsibilities for 'discharge planning' and arrangements inherent in transfer processes. Wenger and Rosenfeld (2001) note that some measures of quality of end-of-life care have been developed, but most have not focused on the processes of care.

A pilot study (Craig & Dereng, 2004) conducted in upstate SC involving 60 randomly selected transfers of those 65 and older in 2003 identified the sources of transfers into hospice by referral source, and identified barriers to seamless transitions. The mean age of patients transferring was 82 years old, and the age group 85 years or older comprised 43% of the sample.

As a whole, these patients were quite ill at the time of the transfer with 44% having five or more sets of symptoms. Approximately 35% of the transfers originated from the hospital, another 12% from home health, 7% from nursing homes, and 47% from private physician offices. Greater than 60 percent of the patients did not have medical information accompanying them at the time of transfer, 52% had no advance directive to guide care, 45% had problems with durable medical equipment at the time of transfer, and another 40% had problems with prescriptions. Thirty-two percent of the sample had problems with both DME and medications.

Previous Approaches/Solutions

Recognizing the disruptions to continuity that transfers cause, a number of strategies have been investigated, recommended, and tried on limited populations. The most promulgated approach has been advance directives, particularly living wills, as a way of communicating preferences for type and amount of treatment preferred and coordinating care across health care venues (Wenger and Rosenfeld, 2001). However, this approach has been found to have limited utility for a variety of reasons. It is unlikely that advance directives will be either widely used by seniors of all socio-demographic population segments, or widely relied upon by multiple professionals to direct care across settings given different state laws that govern legal standing of these documents, and conflicting state regulations governing licensure, certification, or accreditation of different venues of care.

Other approaches that have emerged include: case managers supplied by managed care plans and/or organizations, care plans such as Oregon's *Physician Orders for Life-Sustaining Treatment (POLST)* that accompany patients across settings, communication and advocacy classes for caregivers, and with the diffusion of technology in health care, innovations that enhance the transfer of pertinent patient medical record information at the point of discharge from acute care. The Medicare Prescription Drug and Modernization Act of 2003, signed into legislation December 8, 2003, will allow Medicare to cover the costs of coordinating care for patients with multiple and severe chronic conditions. Of particular relevance to hospice providers is the new benefit which covers the cost of an educational consult by a hospice physician to terminally ill patients in settings other than hospice to perform pain assessments as well as counseling on care options and advance care planning, and regulation that allows nurse practitioners to continue treating their patients who enter hospice (Koppelman, 2004).

Whether either or both of these benefits improves coordination and continuity across venues remains to be evaluated. It is clear, however, that patients and their caregivers want one person coordinating their care (this ranks 13th of 74 items among the terminally ill and 16 of 77 among their caregivers), appropriate timing of referral and transfer (families who felt their loved one was referred 'at the right' time are significantly more satisfied), and more public education about financing and alternatives at the end of life (up to 90% of the public in one survey did not know that care in the home was 100% covered by the Medicare hospice benefit regardless of diagnosis).

Recommendations

It does not appear from a review of the literature that sufficient investigation has occurred relative to the numbers and nature of transfer processes, and the variables that influence the success or failure of those processes from the perspective of different stakeholders that include at least patients, their families, and multidisciplinary providers. It is proposed that more research be funded and conducted to 1) Determine the current state of continuity and coordination, and 2) Explore alternative strategies for improving the processes of transfer between settings. An initiative is currently in process, the SC Upstate EOL Educational Collaborative, partially funded by SC Alliance 2020, to educate providers across settings and set the stage for more research.

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Issue: Mental health and older adults

An area of health care largely overlooked at the national and state levels is the mental health status of persons developing into their later years, a time of life traditionally associated with an increased need for health care services. Although there are, no doubt, interactions of mental health status and physical health problems in aging individuals (Cohen, 1990), mental health problems in late life should not be considered solely as a consequence of aging.

Mental illness in older adults is defined to include dementia-causing conditions and psychiatric disorders and currently affects between 22-30% of the over-65 adult population (Gatz & Smyer, 1992). As the older adult population continues to grow as a percentage of the total population these measures are expected to increase by an additional 10% through 2030, resulting in a total of 23 million older adults diagnosable with a mental illness (Jeste, et al., 1999).

It is clear that many older adults in need of mental health services do no receive the care they need. The South Carolina Alzheimer's Disease Registry estimates that 73% of the 56, 974 persons with Alzheimer's in the state are currently receiving no treatment. South Carolina community mental health centers have not been able to serve more than a small percent of older persons in need of care (5% in FY97-98). The South Carolina Department of Mental Health Inpatient Services has designated just over half of its 2000 beds for older adults. The state currently maintains a waiting list of 3,600 for its community-based waivers program providing home-based support services. The total number of cases of Alzheimer's and related illnesses in the United States is expected to grow over the next three decades and reach an estimated 14-15 million as the baby-boom generation passes through the later years of life.

Dementia: Approximately 15% of older adults will experience the memory loss, confusion and disorientation of dementia-causing illnesses (Ritchie & Kildea, 1995).
Alzheimer's disease currently accounts for over 60% of the total (American Psychiatric Association, 1994). Three to four million individuals in the United States suffer from Alzheimer's, with 300,000 new cases diagnosed each year, for a total health-care, one-year cost of approximately $100 billion. Additional costs for American businesses from the loss of work-related productivity of caregivers who make life adjustments to provide family support is estimated at $33 billion per year.

Of primary importance as additional causes of dementia are Parkinson's disease, Huntington's disease, Creutzfeldt-Jakob disease, and, most significantly for the total, stroke and complications of high blood pressure.

Depression: Chief among the other mental illnesses affecting older adults is depression. Depending on how the study samples are defined, from 5-20% of adults 65 and over living in the community experience depressive symptoms. The difficulty of distinguishing dementia from depression highlights a critical need for accurate diagnoses since even severe depression is often reversible with appropriate treatment. Depression estimates run as high as 37% for residents in primary care settings.

Costs associated with depression are estimated at $43 billion per year in the United States. This total, however, does not include costs associated with reductions in quality of life due to pain and suffering and healthcare costs of excess disability.

Suicide: The feelings of helplessness and worthlessness of depression are often accompanied by suicidal ideation and suicide attempts. Older adults are at greatest risk for suicide as compared to all other age groups. Approximately 5,390 older adults in the United States succeed in committing suicide each year, accounting for 20% of the total number of suicides nationwide (Centers for Disease Control, 2005).

Anxiety: Approximately 5-10% of older adults meet the diagnostic criteria for an anxiety disorder, with phobic disorders being most prevalent. Generalized anxiety disorder is also seen in older adults, with approximately half of the cases having an onset in late life (Le Roux, Gatz & Wetherell, 2005).

Alcohol/Substance Abuse Disorders: Estimates of alcohol abuse among older adults range from 3-9%, with males being four times more likely than females to experience problems (see Butler, et al. 1998, p. 175). These estimates may be low even at the high end of the range given the "hidden" nature of the problem allowed by a retired lifestyle.

Less than 0.1% of older adults use illicit drugs. Most substance abuse problems among older adults result from improper drug usage (overuse, under use, punctuated use), although prescription drug dependence may develop in older adults, particularly among women.

Barriers

Barriers to receiving mental health services include: (see Aiken, 1995)

- older adults often lack transportation to and from mental health services;
- services that exist are often inadequate (too few services, overloaded services, lack of outreach/advertising to promote awareness of a service, etc.);
- older adults received early socialization during an era that promoted self-sufficiency and often associate mental problems with personal weakness. In addition, treatment alternatives are further discouraged because cognitive problems are often seen by professionals and laypersons as a natural consequence of aging;
- only 50% of older adults in need of mental health care receive treatment from a health care provider, most typically a physician with no specific training in geriatrics. Only 3% of the 50% of older adults who need and receive treatment do so from a mental health specialist;
- system-wide lack of resources results in a lack of coordination across service options
- individuals lack resources and knowledge to access a fragmented service-delivery system.

Solution(s) to overcome barriers:

The solutions must include partnerships of governmental agencies with private entities to provide comprehensive services in a "seamless system of care".

Some possible solutions to address mental health issues:

- education programs for persons with mental illness and their families;
- education for caregivers;
- education for professionals who have an older adult clientele;
- general education programs to produce an informed public;

- respite care grants to provide relief for caregivers;
- health and wellness initiatives to combat excess morbidity among persons affected by mental illness.

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Faith-Based Organizations and Social Service Programs and Services for Older Adults

By

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Issue: Faith-based organizations and social service programs and services for older adults.

Statement of the issue as addressed in the paper

Faith-based organizations should become more involved in developing social service programs for older adults. In the current political climate, the government is providing fewer social service programs and future prospects are bleak. The literature provides evidence that religion and faith-based organizations are very important in the lives of Americans, particularly the current cohort of ethnically diverse elders. Churches remain untapped resources for the provision of social services and they can fill the gap.

Historically, the church was the sole provider of services for the poor, the elderly, the orphaned, and the needy. In Colonial America, the separation of church and state became the central focus for the Puritans who urged government to take on responsibility for solutions to societal problems. During the Roosevelt administration, the creation of government-sponsored social services became a national priority as evidenced by the passage of the Social Security Act of 1935. The Kennedy and Johnson years continued the federal government's expansion into social service provision with the passage of both the Medicare and Medicaid Acts in 1965, ushering in the Great Society era. The Reagan-Bush administrations introduced a new era of diminishing federal responsibility through devolution. The policy of devolution of social services to the local level contributed to more federal budget cuts for social programs. The end of welfare as it was known in the 1990s found community members with cuts in food stamp programs, Supplemental Social Insurance, Medicaid, and child welfare programs. Communities with dwindling financial resources are being challenged to meet the needs of their older citizens. As policy-makers concede that the federal government cannot meet all needs, President George W. Bush is supporting the efforts of faith-based community initiatives to provide for the unmet and under met needs of communities and introduced in 2001, The Charitable Choice Act. This provision opened the door for states to contract with religious organizations without impairing the religious character of the organization and without diminishing the religious freedom of the beneficiaries of assistance funded under such program.

Furthermore, from primitive to modern times religion is strongly intrinsic in human life; thus the church, synagogue or mosque has a social responsibility to its congregation. As Simmons (1991) states, "if we don't who will" (p.17)? Religion is important to Americans and in particular to older persons. Over 76% of church and synagogue members are over 50 years of age (U.S. Census, 2000). A Gallup poll reported that 71% of Americans claim to be members of a church or synagogue and 41% report having attended church seven days prior to the survey (Cnaan, 1997). According to Tobin, Ellor & Anderson-Ray (1986) three out of four persons 60 years and older report that religion is important in their lives and four out of five persons older than 65 years of age attend church or synagogue regularly .

Religiousness or spirituality, whether described as institutional or personal, correlates positively with better morale, stronger coping skills, and better physical and mental health. For example, some studies found that depression and alcohol abuse are less prevalent in religious older adults (Zucker, Fair, & Branchey, 1987). Hypertension, anxiety, and cardiac problems are

positively influenced by religious behaviors (Krause, 1991). Older people who are religious are happier, have better coping mechanisms, less depression, and better physical and mental health (Johnson, 1995).

The literature also indicates that older persons prefer social services delivered by faith organizations rather than community agencies. Gulledge (1992) describes clergy as the first persons contacted when families are in crisis. In another study, older persons were asked which programs they would be willing to attend at their places of worship. Over 55 percent responded programs relating to emotional health, 24 percent financial programs, 42 percent health programs, 31 percent legal programs, 49 percent programs relating to personal needs, and 50 percent said recreation and educational programs. Over 70 percent of the respondents reported that they would be more willing to attend social service programs in their places of worship than at a community agency (Tirrito & Spencer-Amado, 2000).

In examining the rationale for the church as a service provider, the literature points to the failure of community social service agencies to provide needed services to older adults. Netting, Thibault & Ellor (1988) found evidence that older adults, particularly ethnic older persons, underutilized community social services. Older adults infrequently use community mental health services and consequently, older adults are frequently untreated for depression, dementia, and alcohol and drug abuse.

Barriers to be overcome in order to act on the issue

Cooperation and communication between community agencies and faith-based organizations are essential**.**

Training is needed to address the lack of leadership of clergy and lay leaders in the development of needed programs and services.

A significant barrier for religious and lay leaders is the absence of a method to develop community action programs in faith-based organizations. The Faith Based Community Action Model (FBCAM) was developed for that purpose (Tirrito and Casio, 2003).

Lack of financial resources among faith-based organizations must be addressed.

Issues regarding the separation of church and stated and freedom from religious influence in the provision of services must be clearly articulated and resolved.

Workable solution(s) to overcome barriers

Church leaders, academicians and social activists can be instrumental in providing needed knowledge and leadership. The religious community has the potential to develop partnerships with the neighborhood community, in order to address the needs of elders. While good intentions are critical, knowledge and collaboration are essential .The diversity of the aging population and the variety of churches, synagogues, and mosques in various communities necessitates the need for programs that are unique to each community.

The old ways are no longer suitable. New challenges require new efforts by the church and the government. Thus, the challenge to restructure the formal service system leads one to examine the potential of untapped natural support systems, the thousands of faith organizations (churches, temples, mosques, synagogues) that can fill the gap of need services for the burgeoning population of older adults.

Recommendations for Action

Increased funding to faith-based organizations for social services and programs for older adults and support for the Office of Faith-Based Initiatives to expand its work.

Training for leaders (lay leaders and clergy) in faith- organizations to develop programs and services for older adults.

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Healthcare: Need to Enhance and Encourage Healthy Lifestyles/Disease Prevention—Nutrition and Aging, Physical Activity and Aging

By

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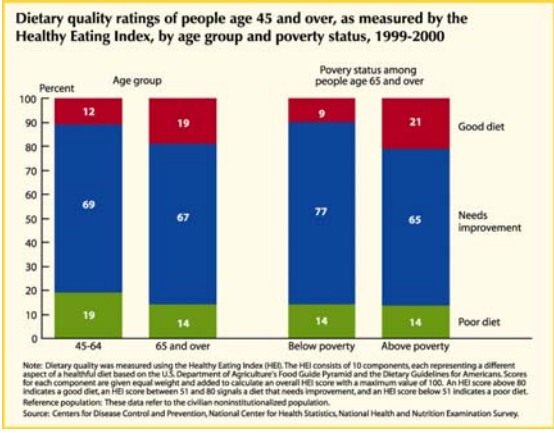
Issue/problem: Healthcare: Need to enhance and encourage healthy lifestyles/disease prevention – Nutrition and Aging, Physical Activity and Aging

The leading causes of death for older Americans are heart disease, cancer, and stroke (respectively). Approximately 45% of persons age 70 or older reported having hypertension, and 21% reported having heart disease. Other chronic diseases included cancer (19%), diabetes (12%), and stroke (9%). The prevalence of chronic conditions varies by race and ethnicity in the older population. Non-Hispanic black persons were more likely to report having diabetes, stroke, and hypertension than either non-Hispanic white persons or Hispanic persons. Cancer was reported by 21% of non-Hispanic white persons, compared with 9% of non-Hispanic black persons, and 11% of Hispanic persons.[1]

Good nutrition and physical activity is essential to the health, independence and quality of life of older adults and are major determinants of successful aging. Dietary quality and physical activity play a major role in preventing or delaying the onset of chronic diseases such as coronary heart disease, certain types of cancer, stroke, and Type 2 diabetes.[2] A healthy diet and regular physical activity can reduce some major risk factors for chronic diseases, such as obesity, high blood pressure, and high blood cholesterol.[3] Physical activity helps to maintain independent living by improving strength, flexibility, mobility, functioning and balance influencing the ability to perform ADL's and IADLs and reducing incidence of falls. [4]



Many older Americans, however, receive sub-optimal nutrition and have a sedentary lifestyle. A majority of older people reported diets that needed improvement (67%) or were poor (14%). Older people living in poverty were less likely to report a good diet (9%) than older people living above the poverty level (21%). Older peoples' scores were lowest for the components of the Healthy Eating Index measuring daily servings of fruit and milk products. [1] Thirty-four percent of persons age 65 or older have a sedentary lifestyle. [4]

Financial Impact

Evidence shows that improving nutrition and increasing physical activity among older adults reduces healthcare costs. The cost of an estimated 30 million people living with cardiovascular disease, diabetes mellitus, kidney disease, hypertension, obesity and osteoporosis – conditions responsive to medical nutrition therapy - is over $300 billion. [6] In 2000, the total cost of overweight and obesity alone was estimated to be $117 billion. [5] The Medicare and Medicaid programs currently spend $84 billion annually on five major chronic conditions that could be significantly improved by increased physical activity, specifically diabetes, heart disease, depression, cancer and arthritis. Medicare spent $10.4 billion on diabetes treatment and services in 2000 and is estimated to spend $12.7 billion in 2004. [5] Physically active people have fewer hospital stays and physician visits and use less medication than physically inactive people. The biggest difference in direct medical costs is among women 55 and older. [5] Adults with poor nutritional status, especially those consuming inadequate food and fluids, are more likely to have serious complications, require institutional or home-based care, and have greater reliance on prescription drugs.[6]

Barriers

About 30 million live with chronic diseases for which nutrition therapies and physical activity can be effective in managing and treating. Meanwhile the vast majority of homebound older adults rely on informal caregivers, most of whom are untrained and unprepared for care management or health promotion.

Although food and nutrition services and physical activity programs are currently provided to older adults through health care, social support systems and senior centers, these services are not universal, or the participation rates are low. For example, while an average of 1.7 million Americans age 60 and older received food stamps, only about a third of older people who are eligible participate in the program.

Solutions

A broad array of culturally appropriate food and nutrition services as well as physical activities and supportive care are vital for maintaining the health of the older adult population and they are needed in the wide variety of settings in which older adults live and receive health care. These include acute, sub acute, skilled nursing, rehabilitation, community health, congregant feeding, home care, adult day care, life care, assisted-living, and nursing facilities.

Public and private initiatives are needed to improve the safety net for nutrition and physical activity among the nation's older adults. Government, academia, the health care community, civic and religious institutions and individuals all have roles to play in assuring that older adults' nutritional and physical activity needs are met. Support and coordination of activities and partnerships are vital if improvements are to be made and sustained.

Support the employment of registered dietitians, who are uniquely qualified to work with older adults, promoting health and functionality to maintain quality of life among the healthy, as well as provide nutrition education for disease management that lessens chronic diseases risk, slows disease progression, and reduces symptoms. Support the employment of certified exercise specialists who have special training in gerontology and the employment of certified health education specialists who are experts in health promotion and health behavior change.

Enhance and support the USDA Food Stamp Nutrition Education Program (FSNE) in targeting older adults with limited resources. FSNE provides educational programs that increase, within a limited budget, the likelihood of food stamp recipients making healthy food choices and choosing active lifestyles consistent with the most recent advice reflected in the Dietary Guidelines for Americans and the Food Guide Pyramid. This national program fosters collaboration and coordination between federal, state and local agencies.

Recommendations

Expansion and funding of federal and state nutrition and physical activity services in home and community-based programs, such as the Older Americans Act Nutrition Program, Food Stamp Nutrition Education (which includes physical activity), and caregiver support programs.

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Oral Health Care Isues

By

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South Carolina White House Conference on Aging 2005
Issue Paper - Research
Oral Health Care Issues

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Statement of the Issue

The terms oral health and general health should not be considered separately. Oral health is important to general health and means more than healthy teeth--you cannot be healthy without oral health. Research is pointing to associations between chronic oral infections and heart and lung diseases, and stroke. Associations between periodontal disease and diabetes have long been noted. For example, infections in the mouth can enter the blood stream and cause serious problems to major organs such as inflammation of the heart valve. The percent of individuals with moderate to severe periodontal disease increases with age. Also, many older persons take multiple medications and at least one will have an oral side effect, dry mouth, which is a risk for oral disease. These diseases and problems can be controlled and prevented through conscientious oral hygiene and oral assessment.[1]

However, there are few dentists across the nation and in South Carolina who are trained in geriatric oral health. Older patients with complex medical conditions are not always given appropriate dental care because dentists and other providers do not feel adequately prepared to care for them. The acute shortage of dentists nationwide is expected to worsen in coming years as dental schools graduate fewer students and many dentists are nearing retirement age. Additionally, it can be predicted that the combination of increasing levels of dental school indebtedness and fee disparities between urban and rural areas will lead to a reduced percentage of dental school graduates locating in rural communities. Culturally relevant geriatric content in dental curricula is needed because of the under representation of minorities in the dental profession.[2,3]

The dental health care of older adults residing in long-term-care (LTC) facilities, especially skilled nursing homes, is problematic.[1] In the LTC setting, there is a lack of time, supervision, and skills of staff to provide oral care for their residents. There are no medical or dental personnel in nursing homes to regularly provide for residents' oral care. Older adults' oral health can be compromised by their inability to care for themselves. Many cannot raise their arms to perform oral hygiene and many are not cognitively aware to take care of their dental needs. This lack of attention to dental needs, including the cleaning of teeth and gums daily, replacement of broken and deteriorating teeth affects a person's ability to eat proper and nutritious foods and can result in malnutrition and even death.

Comparisons of SC with national data on several oral indicators:

- Persons 65+ with a loss of 6 or more teeth due to gum disease is 65.6% for SC as compared to 61.9% for the nation[4]
- Complete tooth loss is 30.2 for SC and 24.4% nationally[5]

- SC is rated 2nd in the nation in oral cancer mortality[6]
- Nationally, oral cancers are primarily diagnosed in the elderly and detection and diagnosis is often delayed with a poor prognosis. The 5-year survival rate for white patients is 56 percent; for blacks, it is only 34 percent.[7]

The Standards for Dental Services for Licensing Nursing Home include the following:

(a) When a person is admitted to a nursing home, an oral assessment by a physician, dentist or registered nurse shall be conducted within two weeks to determine the consistency of diet which the resident can best manage and the condition of gums and teeth. A written report of this assessment shall be placed in the medical record.

(b) Each nursing home shall maintain names of dentists who can render emergency and other dental treatments. Residents shall be encouraged to utilize dental services of choice.

(c) Residents shall be assisted as necessary with daily dental care.[8]

The Healthy People 2010 Objectives[9] include Objectives related to oral health in older adults are

- Increase the proportion of adults who, in the past 12 months, report having had an examination to detect oral and pharyngeal cancers.
- Increase the proportion of long-term care residents who use the oral health care system each year.
- Increase the proportion of persons with diabetes who have at least an annual dental examination.
- Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.
- Increase the proportion of primary care providers, pharmacists, and other health care professionals who routinely review with their patients aged 65 years and older and patients with chronic illnesses or disabilities all new prescribed and over-the-counter medicines.

Barriers to Overcome

- Lack of knowledge among older adults concerning the relationship between oral health and general overall health.
- Lack of public dental insurance -- Medicare does not provide dental benefits.
- Lack of adequate transportation to oral health services in rural areas.
- Poverty and a lack of out-of-pocket funds to pay for oral health care.
- Acute shortage of dentists nationwide with an expectation to worsen in coming years as dental schools graduate fewer students; also many dentists are nearing retirement age.
- Lack of adequate daily dental hygiene care in LTC settings.

Possible Solutions

- Education of faculty, practicing professionals, students, caregivers, and the public about the oral health- general health connection. (In 1993, the South Carolina Geriatric Education Center (SC-GEC) received funds from the USDHHS, HRSA, to develop a 40-hour geriatric oral health curriculum for practicing professionals. One special initiative includes a 2-hour oral, head, and neck skills assessment training for primary care providers to enable them to perform an oral assessment as part of the routine physical examination).
- Inclusion of the older adult in the SC Oral Health Plan (SC-GEC has partnered with SC DHEC, Office on Oral Health, to develop a state oral health plan to include older adults; previously, only children were addressed in the State Plan).
- Development and dissemination of a train-the-trainer program for oral health consultants in LTC settings (SC Oral Health Coalition and the SC-GEC). Consultants would arrange for care, perform regular preventive sessions including how to brush teeth and eat properly, conduct periodic screenings of residents as a preventive measure, provide consultation as to dietary requirements for residents from an oral health perspective, and arrange for mobile dental van visits, and transportation to the dentist.
- Heighten awareness of legislators to the fact that lack of good oral hygiene is preventable and that proper dental hygiene--brushing, flossing, and regular dental checkups can save our nation millions of dollars in health care costs.
- Funding scholarships for practicing dentists and dental hygienists to complete fellowships in geriatric oral health care.
- Creation and distribution of health promotion messages for the public on the oral health-general health connection and on identified health risk factors known to affect oral health such as tobacco and alcohol use and poor dietary practices.
- Make Dental Medicine and Dental Hygiene faculty and students aware of the National Health Service Corps' scholarships and loan repayment to dentists and dental hygienists willing to practice in underserved Dental Health Professional Shortage Areas (see attached SC Dental Shortage Areas Map and employed dentists and dental hygienists in SC).[10,11]

Recommendations for Action

- Conduct a comprehensive study of the role and utilization of dental hygienists, the state practice act to explore their expanded use especially in LTC settings.
- ***Legislate for Medicare reimbursement for dental care for adults 65 and older.***
- Expand Medicaid coverage as a mandatory service for oral health services to eligible adults, including the elderly in long-term care settings and the disabled with special needs.
- Mandate that family practitioners and mid-level providers have training in performing an oral health assessment with the routine physical examination.
- Provide funding for "Best Practices in Oral Health Care" in long-term care settings for adaptation and replication.

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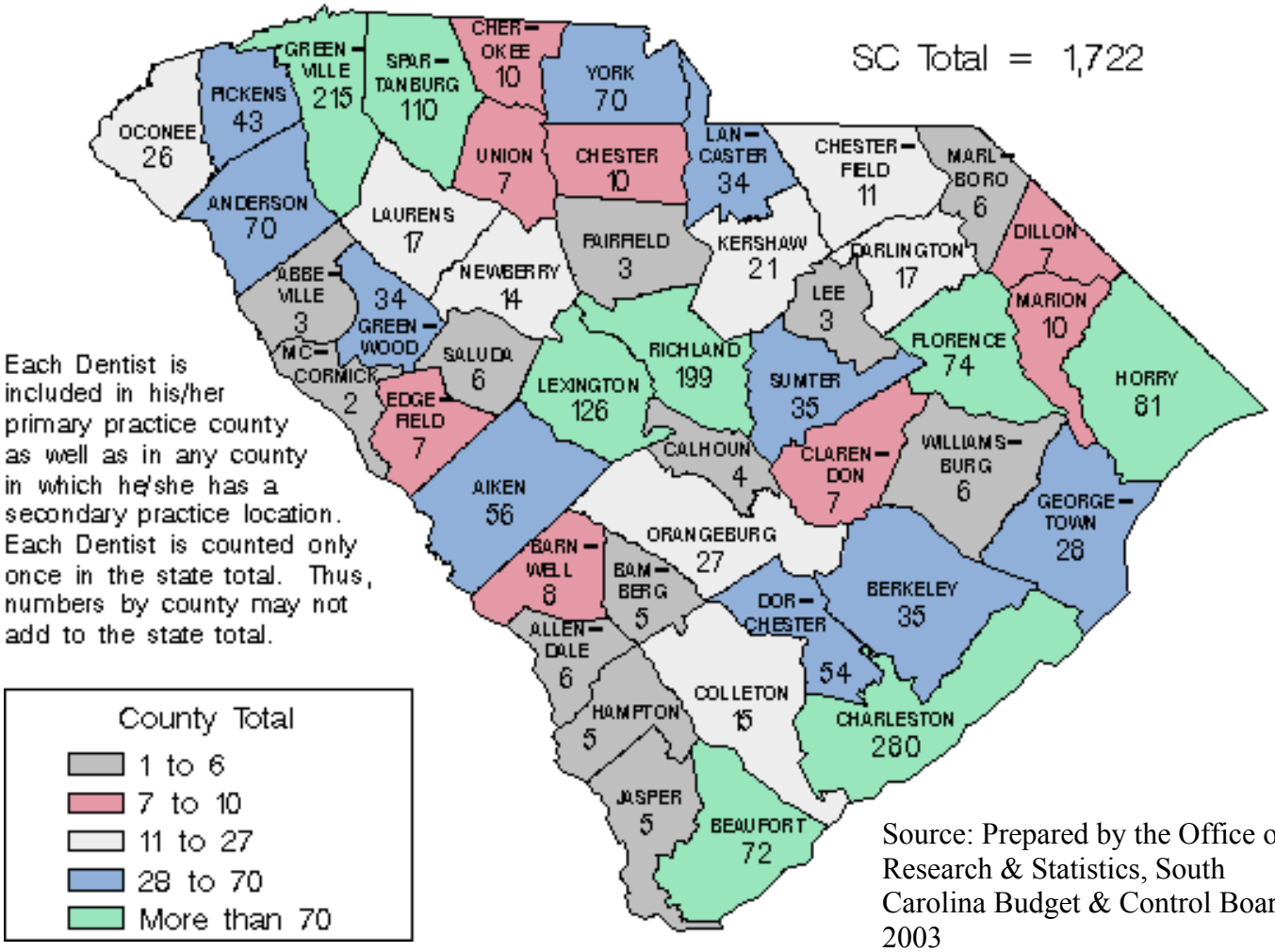
Dentists Employed in South Carolina, 2003



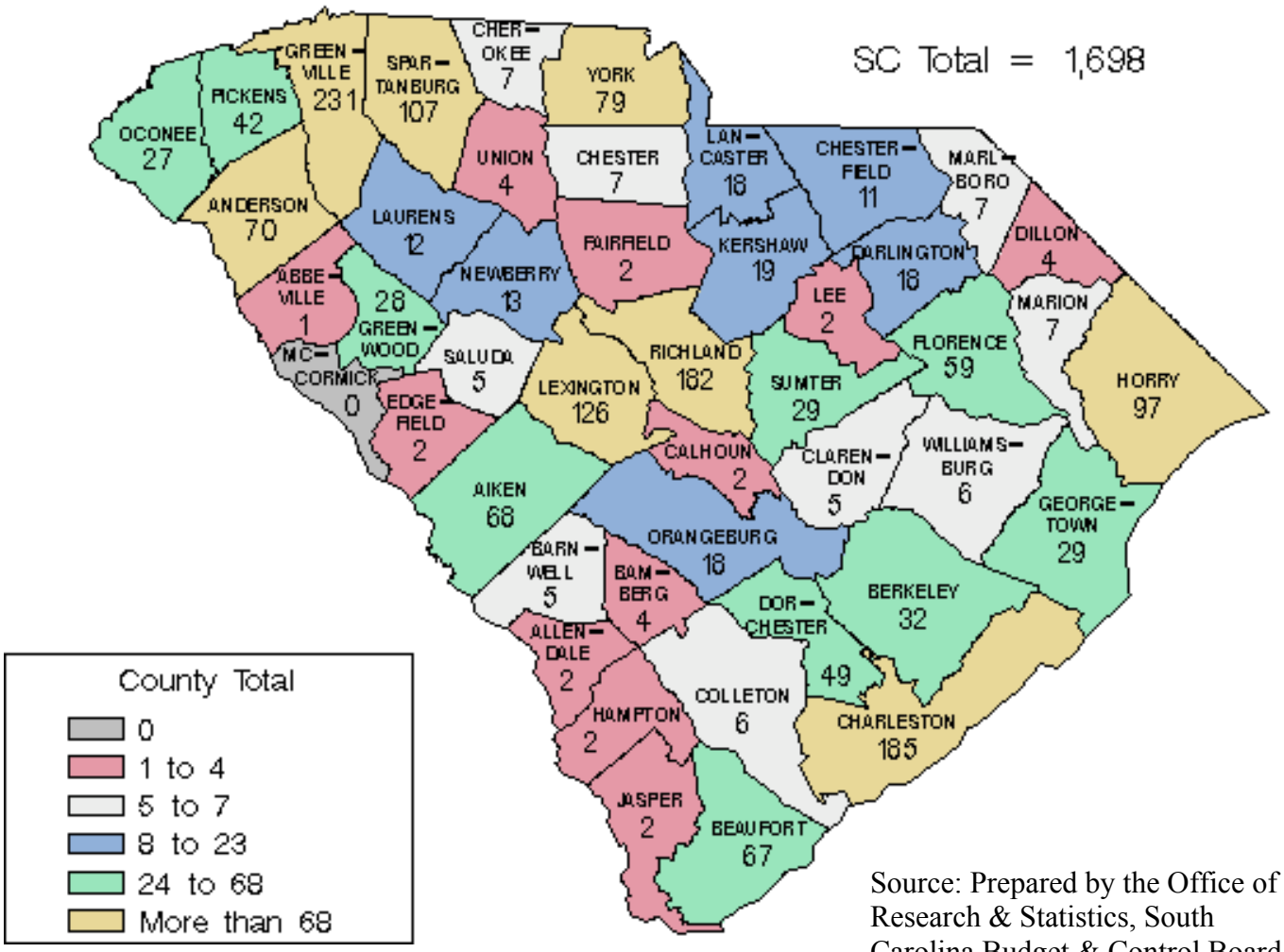
Each Dentist is included in his/her primary practice county as well as in any county in which he/she has a secondary practice location. Each Dentist is counted only once in the state total. Thus, numbers by county may not add to the state total.

County Total

- 1 to 6
- 7 to 10
- 11 to 27
- 28 to 70
- More than 70

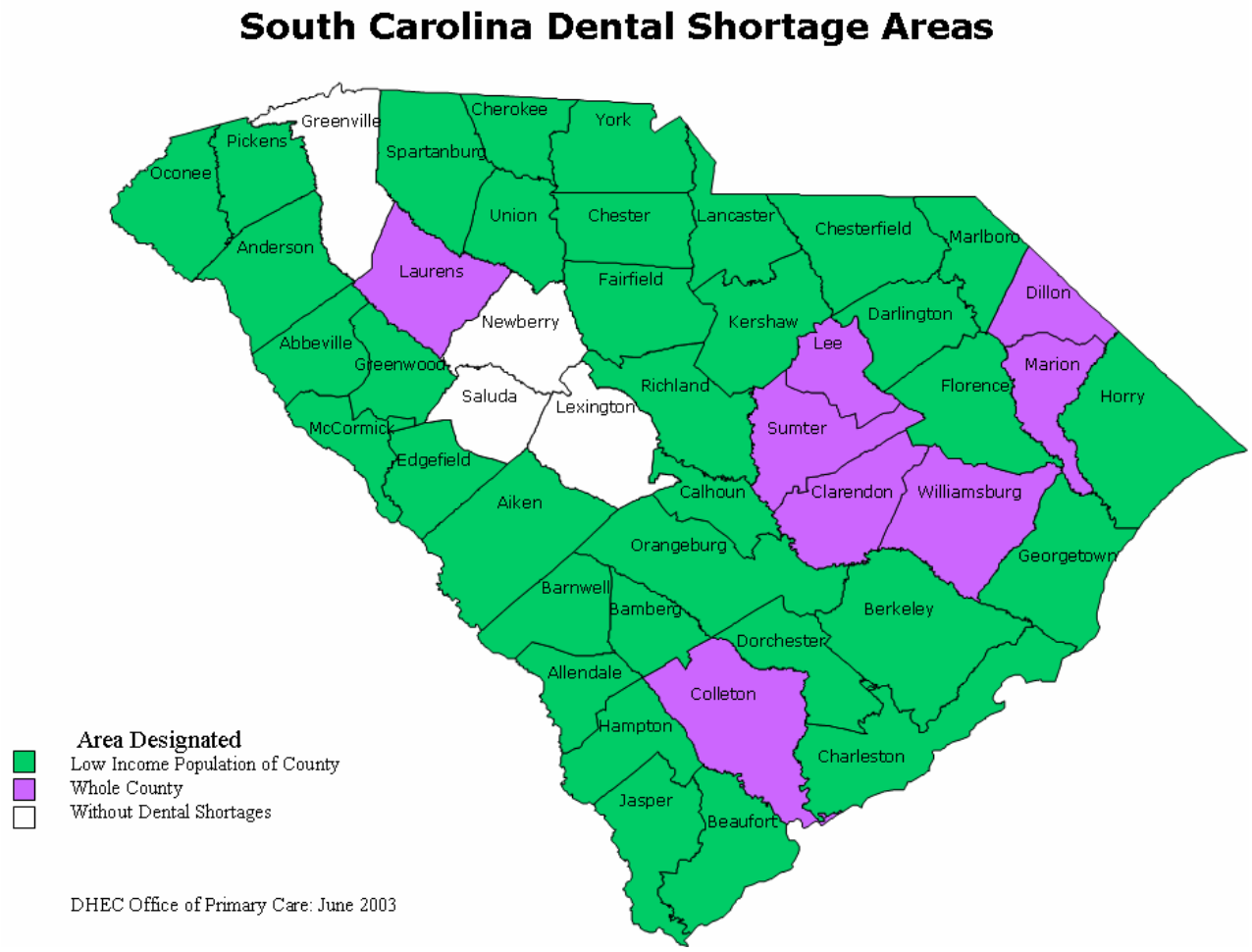
Source: Prepared by the Office of Research & Statistics, South Carolina Budget & Control Board, 2003

Dental Hygienists Employed in South Carolina, 2003



Source: Prepared by the Office of Research & Statistics, South Carolina Budget & Control Board, 2003

South Carolina Dental Shortage Areas



SOUTH CAROLINA
DENTAL SHORTAGE AREAS

COUNTY	AREA DESIGNATED
Abbeville County	Low Income Population of County
Aiken County	Low Income Population of County
Allendale County	Low Income Population of County
Anderson County	Low Income Population of County
Bamberg County	Low Income Population of County
Barnwell County	Low Income Population of County
Beaufort County	Low Income Population of County
Berkeley County	Low Income Population of County
Calhoun County	Low Income Population of County
Charleston County	Low Income Population of County
Cherokee County	Low Income Population of County
Chester County	Low Income Population of County
Chesterfield County	Low Income Population of County
Clarendon County	Whole County
Colleton County	Whole County
Darlington County	Low Income Population of County
Dillon County	Whole County
Dorchester County	Low Income Population of County
Edgefield County	Low Income Population of County
Fairfield County	Low Income Population of County
Florence County	Low Income Population of County
Georgetown County	Low Income Population of County
Greenwood County	Low Income Population of County
Hampton County	Low Income Population of County
Horry County	Low Income Population of County
Jasper County	Low Income Population of County
	Ridgeland Correctional Institution
Kershaw County	Low Income Population of County
Lancaster County	Low Income Population of County
Laurens County	Whole County
Lee County	Whole County
Marion County	Whole County
Marlboro County	Low Income Population of County
McCormick County	Low Income Population of County
Oconee County	Low Income Population of County
Orangeburg County	Low Income Population of County
Pickens County	Low Income Population of County
Richland County	Low Income Population City of Columbia
Spartanburg County	Low Income Population of County
Sumter County	Whole County
Union County	Low Income Population of County
Williamsburg County	Whole County
York County	Low Income Population of County

DHEC Office of Primary Care: June 2003

Community Forums Report

(H)
Research

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

RESEARCH

LOCATION OF EVENT: Capital Senior Center – Columbia, SC

Priority Issue:
Lack of funding for specific chronic diseases as well as healthy aging issues; lack of evidence – focused research and the need for improved linkage between research and practice; general lack of funding to support aging research.

Barriers:
3) The cost of sensitive nature of researching issues.
4) Ageism.
5) The lack of knowledge to translate research into public policy.
6) Definition of quality of life as distinct from a definition of quality of care.
7) Institutional barriers to studying the aging population, such as dementia, nursing home, hospice, etc. Academia is often encouraged to do research in other areas because support is provided in the other areas and not in this one.

Proposed Solution(s):
1) Target funding to programs based on evidence based research.
2) Funders should require researchers to identify practical applications of their research.
3) Funders should require researchers to include community collaboration in identifying issues, setting priorities for research, and implementation of programs.

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
Alzheimer's research, arthritis research, and women's health research.

Barriers:
Recognizing the need for research; governmental regulations.

Proposed Solution(s):
Allocate research funds for senior issues – relax government regulations.

LOCATION OF EVENT: City Council Chambers – Rock Hill, SC

Priority Issue:

Understanding the issues facing seniors is important to identifying possible solutions.

Barriers:

1) What are we doing to change our homes to accommodate seniors.
2) Difficult to change the mindset of people but it is important to do so

Proposed Solution(s):

1) Need to build more accessible housing for elderly.
2) Need to do more to educate doctors about the needs of seniors.
3) New program in South Carolina to train doctors for specializing in geriatrics.

South Carolina
White House Conference on Aging

April 25-27, 2005

(I)
Impact of Alzheimer's Disease on Families/Business/ Government

Issue Papers

Springs D-E

Impact of Alzheimer's Disease on Families, Business, and Government

By

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South Carolina White House Conference on Aging
Impact of Alzheimer's Disease
on Families, Business, and Government

STATEMENT OF THE ISSUE:

Alzheimer's disease is an impairment of intellectual abilities including memory, abstract thinking, and judgment. Other brain changes associated with Alzheimer's disease affect personality.[1] The disease progression often includes behavioral and psychotic symptoms,[1] which add greatly to the stress experienced by caregivers. Related disorders affect individuals similarly. Those with Alzheimer's disease and related disorders (ADRD) eventually require care around the clock, from friends, relatives, or long-term care providers who understand the disease and respond appropriately. Such care will often last for several years.[2] The burdens and costs of caring for those with ADRD are great. Cargivers are stressed physically, socially, and financially. The costs of ADRD extend to greater healthcare costs for caregivers, which affect employers.[3,4] There is no cure for the diseases that make up ADRD. Treatments are of limited help. Providing general medical care to those with ADRD is also complicated by the disease.[5,6]

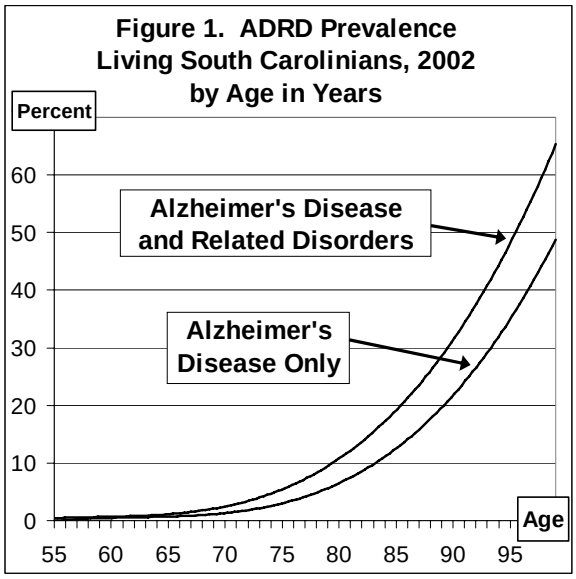
South Carolina has a unique resource for studying ADRD. The South Carolina Alzheimer's Disease Registry is maintained by the Office for the Study of Aging at USC. It has tracked ADRD in South Carolina since 1988.[7] The Registry uses many data sources to provide a comprehensive picture of these diseases. We also use the U.S. Census, to calculate prevalence rates. Our data sources capture records for those who have used medical or social services related to the disease. Thus, our prevalence estimates are for cases that have progressed to a disease stage that already presents costs to families, employers of caregivers, and South Carolina's medical and social services systems. Many individuals who are not represented in the Registry have more mild forms of ADRD, which will become worse.

In 1990, there were 151,000 South Carolinians age 75 years and older. By 2000 there were 215,000 at those ages. By 2025, the number of South Carolinians over 85, where the ADRD risk is greatest, will reach nearly 100,000. In-migration to retirement destinations may raise that number notably. The prevalence of ADRD in the United States is estimated to be over 10 percent of those age 65 and older, and about 47 percent of those age 85 and older.[8] Our South Carolina Alzheimer's Disease Registry provides measures of more advanced disease stages, where those with the disease already use medical care or social services. The challenge to our state associated with caring for these individuals is great. About 250,000 South Carolinians provide this care. Among recent findings from the Alzheimer's Disease Registry:

- 7.8% of South Carolinians age 65 or over have ADRD that has reached a stage that presents notable costs to families, employers of caregivers, or our medical and social services systems. They are represented in our Registry.
- Figure 1 shows how the prevalence of Alzheimer's disease increases with age, using data from the South Carolina Alzheimer's Disease Registry. About 21.5 % of those at ages 85 or older have Alzheimer's disease. Thus, as our State's population ages, we will face many more cases of Alzheimer's disease. Because all other available studies are based on much smaller samples than our statewide Registry, no other research studies can demonstrate results such as those shown in Figure 1.

- Figure 1 also shows the prevalence of all conditions that cause dementias (ADRD). The prevalence of ADRD also rises rapidly with age.
- More South Carolinians with these diseases live in the community (54%) than in nursing facilities (40%) or unknown locations (6%). Those living in the community are cared for by families and/or community long term care providers.

Because individuals with ADRD require specialized care, those who live in the community bring great costs. Caregivers commonly lose much work time, and often experience problems with both emotional and physical health.[3,4] These problems are also costly to employers and to government.[3,4]



BARRIERS TO BE OVERCOME IN ORDER TO ACT ON THE ISSUE

There is hope that medical science may make progress against ADRD. So far, however, the help offered by medicine is modest, and notable advances may lie many years or decades away. In areas we can all work on to address ADRD, there are three key barriers to be overcome:

1. Many families affected by ADRD want to care for their loved ones in their homes. However, currently South Carolina's long term care system favors institutional care for those needing long term care. Waiting lists to obtain long term care services are long.

2. There is increasing evidence that many cases of ADRD might be prevented through healthy lifestyles in younger years.[10,11,12,13,14] It is now known that being overweight or obese, having hypertension or diabetes, having high cholesterol, and getting little exercise are all risk factors for ADRD. Eating patterns also play a role in ADRD risk. Eating few fruits and vegetables, or large amounts of saturated fat, are risks for ADRD. Unfortunately, South Carolinians have some of the greatest ADRD risks in the nation for these factors. Education may also protect against ADRD, independent of these other risks. Again, however, many South Carolinians may be at higher risk for ADRD simply because our citizens have lower levels of education than those of many other states.

3. To understand the changing scope of this issue, it is important to know how many ADRD cases we have in South Carolina. With the recent scientific awareness that ADRD risk may be modified by lifestyle changes, it will be important to maintain our ability to monitor ADRD rates over time to evaluate the success of prevention efforts. Without this resource, we would be unable to evaluate ADRD prevention efforts, which require many years to bring success.

WORKABLE SOLUTIONS TO OVERCOME BARRIERS

1. The difficulty of obtaining long term care services in the home that is faced by families of South Carolinians affected by ADRD can be addressed by legislative action. Long term care in the community costs less than long term care in institutions—approximately $13,000 for home-based care in 2003, compared with $35,000 for nursing homes. Other states have increasingly shifted

long term care from institutions to the home. This barrier can be overcome by the willingness of South Carolina's voters and political leaders to make home-based care as available as institutional care. Additionally, we may be able to make more efficient use of Medicaid dollars for those receiving long term care in their homes, through programs such as the existing South Carolina Choice program for consumer directed community based long term care.

2. The best available scientific evidence suggests that more healthy lifestyles will lower our rates of ADRD in the future. Because even a modest delay in the onset of symptoms can lower lifetime costs of the disease notably,[15] this investment will save money for our state, our families, and our employers. The challenge of lifestyles in South Carolina is well known. DHEC, Clemson University, USC, MUSC, South Carolina State University, and other state organizations have programs in place to address this issue. But the challenge of unhealthy lifestyles in South Carolina may be larger than these current programs can address. More programs of this sort are needed if they are to reach a large number of South Carolinians.

3. The South Carolina Alzheimer's Disease Registry is a valuable resource for monitoring the success of ADRD prevention efforts. Funded by Federal dollars, the Registry can provide this resource with little state financial burden.

4. Individuals caring for those with ADRD continue to find it difficult to access easily available information and referral services.

RECOMMENDATIONS FOR ACTION

1. To address the need for home-based long term care, the South Carolina legislature should act to balance funding for institutional and home-based care. Institutional care will continue to be needed for an increasing number of persons with ADRD as our older population grows, and institutional providers will continue to contribute important services to our state's older population. What will change under this recommendation are the relative trajectories of growth for institutional and home-based care.
2. To avoid a potentially very large increase in ADRD as the baby boom population ages, and as an investment for future generations, South Carolina must work hard to improve our citizens' lifestyles. The DHEC and the state's schools should put priority on promoting healthy eating, exercising, and controlling hypertension and diabetes. These initiatives will not only reduce our risks for ADRD. They will also reduce costs to our medical and social services systems associated with other chronic illnesses.
3. Continue support for the South Carolina Alzheimer's Disease Registry. This resource enables us to understand how rates of ADRD may respond to our state's prevention efforts.
4. Increase funding for the Alzheimer's Resource Coordination Center (ARCC), to enhance respite and education seed grants.
5. Fund information and referral services.
6. Promote early ADRD screening. This recommendation is designed to help families with advanced planning to deal with ADRD.

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Impact of Alzheimer's Disease on Other Related Dementias on Families

By

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The Impact of Alzheimer's Disease and Other Related Dementias on Families

Issue Paper for the 2005 South Carolina White House Conference on Aging

Frances L. Brannon

Issues/Problems

- *In 2003, the South Carolina Alzheimer's Disease Registry reported that there were 42,758 persons in South Carolina who were affected with Alzheimer's disease or a related dementia (ADRD). Approximately 250,000 persons care for these individuals.* ***The Registry predicts that the number of persons affected by dementia will almost double in the next 15 years and nearly triple in 25 years.***

- *Eighty percent of care for persons with Alzheimer's disease or a related dementia is given in the home by family or friends.* ***The physical and emotional demands on unpaid caregivers are huge, especially for those caring for a person with dementia.*** *Caregivers use prescription drugs for depression, anxiety, and insomnia three times as often as the rest of the population. "More than one-third of caregivers provide intense and continuing care to others while suffering from poor health themselves."*[4] *Alzheimer's caregivers are more likely to report feelings of isolation and family conflict over caregiving.*

- *With the divorce rate of Baby Boomers at 50% now, it is likely that by year 2011, when the first Baby Boomers turn sixty-five, more persons with dementia will be cared for by a "single head of household". "Estimates of the percentage of family or informal non-Alzheimer's caregivers who are women range from 59% to 75%. With a poverty rate of 12 percent (compared with 7 percent for men), women over the age of 65 account for more than 70 percent of older adults living in poverty."*[5] *As compared to non-Alzheimer's caregivers,* ***seventy five percent of Alzheimer's caregivers are women****, and one in three have children or grandchildren under the age of eighteen living at home.*

- *"****Alzheimer's caregivers report higher levels of financial strain****. Almost one in five have household incomes below $15,000 and only 11% have incomes of $75,000 or more. Non-spouse caregivers who are living with and providing financial support for the person who has Alzheimer's report spending an average of $261 a month of their own money for prescription drugs, clothing and other out-of-pocket expenses. This does not include what is being spent from the patient's own resources. Nor does it take into consideration the huge costs the family will incur when the person needs full-time paid care at home or in a nursing home or other residential care facility."*[6] *In year 2003, care at home for an individual with Alzheimer's disease cost approximately $13,500. Care in a nursing facility with Medicaid reimbursement costs approximately $35,000. The average cost throughout the disease process for a person with Alzheimer's disease or a related dementia is $174,000.*

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- ***Alzheimer's caregiving has a serious impact on workers outside the home as well as the workplace****. Over 7 in 10 caregivers are employed at some of the time they are caregivers. "A majority of those employed caregivers report missing time from work, taking a less demanding job, choosing early retirement, turning down a promotion, or giving up work altogether."*[7] *"Employer failure to address family issues can be costly. According to a study by Metropolitan Life Insurance Company, the nation's employers may lose as much as $29 billion annually in lost productivity, rehiring and retraining costs and absenteeism."*[8] *"It is estimated that 46% of Alzheimer's caregivers work full-time, 14% work part-time, and 19% are not employed."*[9]

Barriers

- *Restricted coverage to a limited set of authorized providers by third party payers, such as Medicare and Medicaid, limiting caregivers' options of finding better and more affordable services elsewhere.*
- *"Complex bureaucratic systems that oversee coverage rules that define and restrict the amount, duration and scope of services that will be paid for as well as reimbursement rates."*[10] *Caregivers may be left with gaps in coverage of unmet needs for their Alzheimer's care receiver that could have an adverse affect on the quality of life, health and safety of the person with Alzheimer's and the caregiver's entire family.*
- *Lack of financial resources to provide for the caregiver's living expenses when the added financial burden of Alzheimer's caregiving limits the caregiver's ability to work or to increase financial stability through promotions or increased job duties.*

Solutions

- Increase financial assistance to informal (family or friends) caregivers for Alzheimer's persons so that the person can remain at home for an increased amount of time without institutionalization or throughout the duration of the disease**.** There are currently 42,758 Alzheimer's patients in the Alzheimer's Disease Registry. Of these, 17,241 are in nursing homes. Using conservative estimates of $35,000 per year to place these individuals in a nursing home, the annual cost would be $603,435,000. The remaining 22,973 live at home. Assuming that the cost would be $13,500 to maintain these individuals in their homes, the annual cost would be $310,135,500. The total cost is $913,570,500. A large portion of this cost would be borne by the Medicaid program. Families or informal caregivers pay for a considerable portion of this cost. If all Alzheimer's Registry patients resided in nursing homes the cost would be approximately $1.5 billion. South Carolina needs to find ways to assist and support caregivers in

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[7] Ibid.

[8] "Caregiving and Its Impact," Barbara Kelley, Lieutenant Governor's Office on Aging, South Carolina, 2004

[9] "Who Cares? Families Caring for Persons with Alzheimer's Disease,' a report of the Alzheimer's Association and the National Alliance for Caregiving, 1996

[10] "Consumer Directed Home Care: Effects on Family Caregivers," Pamela Doty, PhD, Senior Policy Analyst, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and human Services, October 2004

maintaining their loved ones and friends at home as long as possible in order to avoid or delay institutionalization as long as possible.

- *Give informal caregivers a choice and "flexibility in service alternatives within a system that is responsive to the needs of individuals with the disease and their caregivers."*[11]

Recommendations

- *Subsidize informal caregivers on a sliding fee scale during their caregiving experience so that they will be able to provide care at home and maintain a standard of living above the poverty level.*
- *Offer low cost health insurance and retirement benefits if a caregiver must stop working to provide care.*
- *Encourage employers through tax breaks to support caregivers "with family friendly policies in the workplace such as flextime, telecommuting, job-sharing, counseling, dependent care accounts, information and referral to community services, adult day care and more."*[12]
- *Allow caregivers to choose the services they need and the option of finding better and more affordable service providers, including other family members.*

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[12] "Caregiving and Its Impact," Barbara Kelley, Lieutenant Governor's Office on Aging, South Carolina

Economic Impact of Alzheimer's Disease on Business

By

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ECONOMIC IMPACT OF ALZHEIMER'S DISEASE ON BUSINESSES

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Presented to the 2005 South Carolina White House Conference on Aging
Springmaid Beach Resort Myrtle Beach, South Carolina
Impact of Alzheimer's Disease on Families, Business, and Government
April 26, 2005

Statement of the Issue

A woman in Anderson is determined to keep her mother, who has Alzheimer's Disease, at home (personal communication) and feels strongly that she, herself, needs to be her mother's caregiver. She is, however, balancing caregiving with her work as a school custodian. The school has accommodated by allowing her to take time without pay to care for her mother. They have assured her that they would help her keep her job as long as possible. The school has advised her of a few resources and of course she has been involved with the Upstate Alzheimer's Association's programs, including its respite program. Even so, the costs to the school district in lost productivity are significant, and the loss to this worker's limited income has been difficult to absorb. It is a Catch 22 problem for business as well as for the individuals who must care for loved ones with Alzheimer's disease.

In 2002, The Alzheimer's Association commissioned Ross Koppel, PhD., a sociologist at the University of Pennsylvania, to prepare a study to document the heavy burden of Alzheimer's disease on American businesses (Koppel, 1992). Some of the results were startling and although now, only two years later, a bit dated, his study is a call to the business community to help reverse the course of Alzheimer's disease. But have businesses taken initiative in this direction? What is the impact on business? And what do businesses need to do to help ameliorate this problem?

Barriers

Workers struggle to balance the overwhelming responsibilities for a loved one with dementia with their job obligations. This struggle leads inevitably to absenteeism, productivity losses, and replacement costs—*and* this costs businesses $36.5 billion annually (Koppel, 1992). The business share of health and long term care expenditures for people with Alzheimer's adds another $24.6 billion annually to these lost productivity costs (Koppel, 1992). The total cost of health care and health research expenses of AD are estimated to be $67 billion dollars and businesses pay 37% of these costs as well. The most significant cost of Alzheimer's disease is measured by the devastation it wreaks on people of course, but its dollar costs to businesses is significant.

The total business costs for Alzheimer's disease in 2002—direct losses plus health care costs—was $61.146 billion (Koppel, 1992). These figures are expected to increase to the point that they will be unsustainable by the middle of the century when baby boomers exert their influence. It is known that Alzheimer's is one of the most expensive diseases to society in general, exceeded only by heart disease and cancer (Doty, Jackson, & Crown, 1996; Fox, 1997; Fredriksen-Goldsen & Scharlach, 2001). With the growing number of elderly, the costs will increase almost four-fold in the next few decades.

Over four million Americans have Alzheimer's disease and 90 percent of them are supported at home by caregivers (Evans, 1990). Around 64% of these caregivers are in the work force, 81% of which are employed full time and 18% employed part time (US Department of Labor, 1999). It is estimated that caregivers are absent approximately 23 days a year to take care of their loved ones. This costs between two and five thousand dollars per worker per year (Metlife Mature Market, 1999), or over $10 billion yearly (Koppel, 1992). Lost productivity adds another $18 billion to these costs. Caregivers will suffer physical and mental problems that require medical treatment and use of medication at higher than normal rates (National Alliance for Caregiving and American Association of Retired Persons, 1997). Workers may be prevented from taking opportunities and business travel and there is higher stress and distraction on a caregiver. The trickle down to the supervisor and the other workers can have further productivity consequence. These figures do not even account for the effect of losses to institutional memory (Fredriksen-Goldsen & Scharlach, 2001).

Between one-tenth and one-fifth of caregivers are forced to leave the workforce (National Alliance for Caregiving and American Association of Retired Persons, 1997; US Department of Labor, 1999). 7% of employees retire early and 10% will quit a job due to the caregiving burdens (US Department of Labor, 1999). To an employer, the burden of a worker's departure includes the costs of termination, hiring and training replacements, vacancy cost while the position is open, and productivity attenuation until the new hire is up to speed (Fitz-Enz, 1997).

As one might suspect, studies find AD caregivers are more likely to use Employee Assistance Programs, when available. Usage of EAPs by the 39% of full time worker/caregivers with access to those programs is $63.56 million (Scharlach, Lowe, & Edward, 1991).

The percentage of family or informal caregivers who are female is estimated to range from 59% to 75% (Alliance, May, 2003). The average caregiver is age 46, female, married and working outside the home earning an annual income of $35,000. Although men also provide assistance, female caregivers may spend as much as 50% more time providing care than male caregivers.

The Alliance 2003 research also reported that absenteeism and replacing employees who quit in order to provide care have serious financial consequences to employers. The cost to businesses to replace women caregivers who quit is estimated at $3.3 billion. Absenteeism among women due to caregiving costs businesses is estimated at almost $270 million. The cost to businesses because of partial absenteeism, (extended lunch time, leaving early or arriving late) due to caregiving has been estimated at $327 million. Caregiving related workday interruptions add another $3.8 billion to the burden borne by businesses.

In 1999, the MetLife Mature Market Institute sponsored a pilot study called, "The MetLife Juggling Act Study: Balancing Caregiving with Work and the Costs Involved," which followed up on a subset of 1997 National Alliance of Caregivers/AARP program participants. The study assessed the losses caregivers experience by measuring long-term effects of wage reductions, lost retirement benefits, compromised opportunities for employment promotions, and stress-related health problems. Nearly two-thirds of the caregivers surveyed reported that their eldercare responsibilities had a direct impact on earnings.

A Human Resource Manager in the upstate South Carolina area said that local businesses are just trying to survive in many situations and simply cannot afford the costs in time and money that need to be invested in this problem. A few years ago it was possible for employers to spend the time to assist persons with caregiving situations. With the increased competition of a globalized economy, however, once discretionary resources are now needed to keep many U.S. jobs afloat and organizations are struggling to maintain the status quo. Consequently we may be endangering the future to survive the present.

Solutions

In an article entitled "Eldercare and its impact on the workplace-Health Care Services (LivHOME, 2003, May 5), Bunni Dybnis, veteran eldercare expert, was quoted as stating that companies are increasingly responding to their employees eldercare needs by including geriatric care management benefits to assist the family caregivers in caring for the elder relatives. Employee Assistant Programs are now recognizing the shift in dependent care issues (LivHOME, 2003, May 5). In the interest of maintaining employee productivity and retention, it is a significant benefit to employers to examine the human factors affecting working caregivers and to support employees in their ability to plan for and meet the long-term care needs of their loved ones.

Despite such efforts, the overall cost of Alzheimer's to society in this nation has been estimated conservatively at $100 billion, which is a low and underreported amount (Koppel, 1992). With a gross national product in the United States of a little over 12 trillion dollars, the costs of Alzheimer's represent 0.8% of the GNP! It is estimated that business taxes contribute only $176,115 million toward research for Alzheimer's disease (Koppel, 1992). Given the costs to society in general and to businesses in particular, this is a disproportionately small response to the problem

Recommendations for Actions

How do persons deal with their actual difficult situations of trying to hold positions and be productive? Some creative approaches have been reported in the literature. A story from *Advances*, the Alzheimer's Association Newsletter, Fall 2001 edition entitled "Easing the Stress of Balancing Work with Caregiving Responsibilities" included the following suggestions:

- Take advantage of the Family and Medical Leave Act
- Enlist the support of employers for flexible reduced or part-time hours

- Work at home/telecommute
- Take advantage of EAP at the workplace
- Access resources and services in the area
- See if employer can set aside pre-tax dollars to pay for elder care
- Have a support network of alternative caregivers
- Seek out professional counseling and support groups
- Learn all you can about Alzheimer's so you know what to expect in the future (Advances Editor, 2001)

While these solutions are helpful, it is still evident that businesses will continue to lose billions of dollars because of the caregiving dilemma. What is the answer?

The most important thing that needs to happen before Alzheimer's disease overwhelms us all is to make businesses aware of the impact (Koppel, 1992). It is imperative that there be increased public and private investment in research to find a way to prevent Alzheimer's or stop its progression. Businesses must find better ways to support caregivers by establishing affordable quality long term care that will make it possible for workers to balance their responsibilities to their family and their employer. Businesses might even provide day care for the elderly analogous to day care programs offered by some for children.

The problems are thorny and costly, and there is no easy answer. But it is a problem that cannot be ignored. We cannot afford to wait until Alzheimer's overwhelms our society, for any solution we can come up with at that time will be made at debilitating expense and at significant personal cost to caregivers. We must quit ignoring this problem and deal with it now.

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Community Forums Report

(I)
Impact of Alzheimer's Disease on Families/ Business/Government

~None Submitted~

South Carolina
White House Conference on Aging

April 25-27, 2005

(J)
Need to Develop Senior Friendly Communities

Issue Papers

Atlantic A

Need to Develop Senior Friendly Communities

By

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White House Conference on Aging
Position Paper
Need to Develop Senior Friendly Communities
Submitted by Nancy Ogle
Senior Centers of Spartanburg County
April 5, 2005

1. Statement of the Issue:

Issues of critical importance to the elderly population of Spartanburg County are crime and safety, poverty, abuse and neglect, transportation, mental health, social and physical isolation, cost of medicine, and housing. From research and first-person accounts we know that older people prefer to live independently, in their homes and connected in their community. Senior citizens are a diverse group. One size does not fit all. Great improvements in medicine, public health, science, and technology are enabling today's citizens to live longer, more productive, and healthier lives. Younger, more affluent, and better-educated seniors seek activities that emphasize social and personal involvement. They are quite willing to volunteer, lead or follow if the activity has value and provides a sense of fulfillment. Families, agencies, and communities want to minimize the economic and health care costs associated with an increasing older population. Family caregivers and individuals want to be able to have a choice. Older people want respect, dignity and continuity. All of these goals are achievable when communities, organizations and the people work together to ensure consistent and appropriate support.

2. Identification of the Barriers:

- Our elderly citizens are living longer with the greatest growth in those ages 85 and above. While medical advances have helped make this possible, our social support structure in public, private and nonprofit sectors has not kept pace with the demand.
- Changes in family structure, cost of medical care, and a greater number of elderly with complex illnesses all have an impact on the economics of aging.
- Senior citizens living in rural areas suffer greatly from a lack of access to necessary programs, services and opportunity.
- Our failure in providing an environment where younger, vibrant seniors feel free and involved, and want to participate.
- The lack of a structured and centralized community case management process.

Listed below are some of the barriers expressed most frequently when changes, or a new or an innovative concept, to aging services arises.

(a) That was tried years ago and it did not work.
(b) People won't pay for aging services.
(c) Our clients are poor, feeble and uneducated.
(d) Older people don't want to make choices.
(e) A country club concept? Are you kidding me!
(f) Other agencies don't have enough funds, space, staff (fill in the blanks)
(f) Turf, turf, turf, money, money, money,

Spartanburg County's population is growing older and living longer. This trend impacts adult care services, case management and skilled long-term services. It may also require human service agencies and government programs to further support the needs of an aging citizenry. The U.S. Census Bureau estimates the 60+ populations *will grow by 102.5% by 2025*. As baby boomers age, the sheer numbers could overwhelm the social and health care systems that are

already stretched to their current limits by an era of public desire to limit the growth and reach of government. As a caring society we should not expect the solution to come from government. One solution with proven results is a Senor-Friendly Community brought into being through grass-roots effort, nurtured by public, private and nonprofit organizations, and carefully tended by local people.

3. Proposed Solutions:

A Senior Friendly Community is a community where everyone is involved. It is centrally located and user friendly. It is a collaborative endeavor that creates a community environment and brings together, people, staff, technology facilities, support and outside services, and expanded funding opportunities Here older adult have easy access to programs, services, and resources. Families and caregivers are familiar with each other and the greater community. Volunteers of any age are linked to opportunity and a friendly environment. Facilities are light, bright, well appointed and open all day. Children, parents and grandparents participate in local and structured activity. The business sector, interfaith groups and the downtown are key players. Healthcare and drugstore personnel participate in classes and seminar planning. Affordable and desirable housing is within walking distance. Public, private and nonprofit agencies collaborate in fund raising, advocacy, and staffing. Access to the full range of senor services easy, convenient and hassle free are under the senior friendly umbrella. Local foundations, United Way, school system, library, arts groups and others find the time to lend guidance, resources and technical expertise.

4. Recommendations to the Conference:

Is it good business to anchor a senior friendly community with a senior center? Current market research substantiates the need for senior friendly communities. When you consider that 12% of the population of the U.S. is over the age of 65 from a business standpoint it makes sense. The second largest population of senior citizens lives in the Upstate. The foothills of SC is now a retirement destination of choice. In the U.S. economy persons over the age of 50, controls 7% of the current private sector wealth. Retirees in our region are bringing significant resources and fueling the economy. Retirees are looking for volunteer opportunities that help them to assimilate and adapt to their changing status. The prospect of economic development, entrepreneurship and tourism drives small towns and rural communities in encouraging mature adults to locate to their area. A well-designed senior friendly community can integrate senior programming into the fabric of small and/or rural towns.

Discussion: Powerpoint presentation concept of the VSP Club of Senior Centers and the Rutledge Project in Spartanburg County.

Funding for Senior Citizens Programs and Activities

By

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2005 South Carolina White House Conference on Aging
April 25-27, 2005
Springmaid Beach, Myrtle Beach, SC

Topic: Developing Senior Friendly Communities

Issue: Funding for Senior Citizen Programs and Activities

Funding for Human Service Programs has been an issue for many years, as politicians try to balance budget constraints with the pressure to adhere to the wishes of their constituents, without raising taxes. Baby Boomers have become an enormous voting block that requires political leaders to deal with aging issues if re-election is to be successful.

In 1995, Horry County began to realize incredible growth from "in-migration", particularly the Senior Adult retiree population. (200% increase in 55+ age group from 1990-2000) In conjunction with the rise in the senior population came a demand for more services and programs for seniors.

Horry County Council on Aging, Inc. which is designated as the focal point for senior access was unable to provide adequate levels of service without larger levels of funding. In 1995, HCCOA received $78,000.00 from Horry County Supplemental Budget, the total budget for FY 1994-95 was $512,000.00.

Barriers To Addressing The Issue:

- Very little information was being circulated publicly about HCCOA; it's services, programs, mission, and clientele were not generally talked about within the human services ranks or within the political arena.
  Generally, HCCOA was simply recognized as the "meals on wheels" program, and usually no mention of any other services or programs was shared about the agency.
- Horry County was in the middle of heated debates regarding growth, taxes and services; All in an election year for many politicians.
- Finally, a debate surfaced about "local vs. northerners". The emphasis was on who should "pay the bill" on growth issues. Roads, schools, fire/rescue, services, etc. were under great stress from the shear numbers is growth to the County.
- Not many people were interested in the topic/subject of senior citizens especially if it had no bearing on them. (eg. The 24 yr old male voter was not interested in an issue that could raise taxes.)

Solutions to Overcoming Barriers:

With HCCOA being at a cross roads with regard to its own position within the community as a service provider, the decision was made to pursue local funding through a countywide referendum to designate HCCOA as a special tax district in order to get uniformed, dedicated tax millage funding on a yearly basis.

The following solutions were developed to address these issues: Senior citizen population growth; Services and programs for senior adults; Funding inadequacies, Public relations; Education of the general public on "aging" issues; and political attitudes toward senior citizens.

- Mobilize Senior Citizens through countywide advisory committees
- Create Priority List of Problem Areas and Issues
- Develop a Public Relations Campaign
- Utilize statistics, demographics and research
- Collaborate with AARP and other 50+ groups
- Develop Public Speaker groups.
- Utilize young people at Colleges and Universities
- Make "Aging" issues a Political campaign platform
- Highlight Senior Adult Volunteer Contributions to County
- Develop educational materials showing tax dollars saved by providing community based services
- Recruit community leaders, politicians
- Publicize funding needs

Actions to Implement Solutions:

Solutions can be thought up and written quite easily, "implementing" ideas and solutions is a very different thing. As most of us have experienced, 80% of the effort comes from 20% of the people. The following are ideas to get your goals and objectives from paper to the pavement.

- Selling the importance of Senior Citizen programs and services must be a constant focus. Sell, Sell, Sell!
- Political leaders love to support a great idea that equates into votes. Public appearances by political leaders with large support crowds are a must.
- Get every community in your county to weigh in, Their voice is important and WILL be recognized
- Churches must be supportive of the goal. ALL Churches.
- Every Community must be convinced that they will receive their share of the fruits of their labor.
- Follow Through and Follow-up
- Create events that are "media worthy"
- Utilize the Media to promote solutions
- Bring Board Members and Advisory Committees Together to Celebrate success.
- Don't Give Up!

The Referendum Question was placed on the ballot in November 1996. The results were: 67% in favor, 33% not in favor. A resounding victory for Senior Citizens and Horry County Council on Aging. Today, HCCOA's budget is $1,912,000.00; with $518,150.00 from the special tax district designation.

Developing an Active Adult Retirement Community

By

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Developing an Active Adult Retirement Community
By Glenda W. Morgan

There are several considerations involved in the development of an active adult retirement community (AARC). This article will discuss only three of these considerations. First, the active adult consumer requires several components to be in place in order for them to consider a purchase. Secondly, the acceptance by the surrounding community is a top initial priority. Thirdly, integration of the residents in the surrounding established community is also a challenge and must be planned at the beginning of the process.

Components that the Active Adult looks for:

When a retired couple is considering a move they will use previously acquired knowledge from earlier visits, information from acquaintances or research. There are other factors taken into consideration such as lifestyle, cost of living and acquaintances that have already moved to the area under consideration. The couple will have a preconceived idea of what they are looking for. They look for a location that will have the features of the environment that will enhance the lifestyle they seek for their retirement. There is a strong factor of recreational avenues, entertainment, future educational opportunities, restaurants, appropriate churches or temples, and opportunities to participate in various volunteer activities or part time employment. Another consideration is the distance to family, neither too close nor too far.

Where to Retire magazine found the following to be the most important considerations for its readers:

1. low crime rate
2. good hospitals nearby
3. low overall cost of living
4. mild climate
5. low overall taxes
6. low housing cost
7. friendly neighbors
8. major city nearby
9. no state income tax
10. active social/cultural environment

Active adults expect a distinct, adult-oriented lifestyle choice rather than simply a place to live. The lifestyle choice is more important to the purchaser than the home itself in most cases. However, consideration must be applied to the amount and scope of the amenities that the completed community can support. Developers must create a lifestyle and be able to have some of this lifestyle in place. The mature buyer does not purchase promises.[13] There is more to creating a lifestyle than simply a clubhouse, a swimming pool, and a list of events. There must

[13] Diane R. Suchman, *Developing Active Adult Retirement Communities, p.29*

be an image created for the community that the prospect can visualize as being congruent with the image they have designed for their retirement. People moving into an AARC want more than what they are leaving. They want to explore new interests and try new experiences. The AARC could be compared to a college campus but also needs to have a resort feel to the community. The active adult is looking for what they "have earned and deserve". There needs to be an environment of security, comfort, freedom from responsibility, and independence. The AARC needs to provide varied and numerous opportunities for interaction with their peers. Market preferences are continuously evolving.

Paving the Way through the Red Tape

Developers proposing an AARC development should expect local opposition. The need to convince the local authorities and gain public acceptance would best serve if done during the planning period. More often than not, it is necessary to 'sell' the community on the benefits of an AARC in order to gather the community support. Sharing of many statistics that detail the many benefits of an AARC, such as the following, can be valuable in alleviating some fears.

- Active adult retirement communities provide local governments with economic benefits. According to the National Association of Home Builders (NAHB), under conservative assumption, the one-year benefits of 100 single-family AARC homes in a typical city- not including ongoing participation in the local economy- include more than $10 million in local income, approximately $850,000 in local taxes, and 253 local jobs.[14]
- In addition to financial benefits, the adult residents add human resources to the surrounding community by providing experienced, active citizens and volunteer workers.
- AARC do not add any children to the school system, the single greatest tax burden associated with non-age restricted communities.
- Older people drive less and will avoid the peak driving hours. In 1997, the Institute of Transportation Engineers estimated that an AARC generated 23% as much traffic as a non-age community.[15]

Additional assistance can be brought about in the form of a gift that the receiving community desires, such as a park or nature preserve. Investigation of a community desire or need that the local government cannot afford can lead to an appropriate gift that would pave the way to a favorable outcome.

Integration of the New Residents

Once the local government officials and the community have accepted the construction of the Active Adult Retirement Community, there is a need to integrate the new AARC residents into the established community. Developers should establish strong relationships with local and municipal politicians and officials. Every opportunity should be taken to leave a positive legacy for the AARC community residents with the local governments, trade organizations and contractors. The developer should plan to be part of the greater community by encouraging

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[14] National Association of Home Builders/National Council of Seniors' Housing, *Winning Strategies for Approval: Impact on Schools(brochure)*

[15] Institute of Transportation Engineers, *Trip Generation,* 6th ed. (Washington, D.C.,1997)

residents to serve on councils, committees and task forces and by donating to local charities and community groups.

Over time, large-scale AARCs may affect the balance of political power in the host community. Older people tend to vote in greater numbers than younger citizens and to take a keen interest in local politics. Although some communities fear that older citizens will not support bonds and taxes that benefit schoolchildren, the record on this issue is mixed. In some places, residents of AARCs have indeed voted down the school bonds or seceded from the school districts rather than pay school property taxes. In other places, seniors are strong supporters of local schools, serve on school boards, and volunteer in the local school system. A key factor appears to be whether or not a relationship between the schools and the senior citizens is developed early in the life of the AARC.[16] The more the AARC community residents are accepted as members of the exiting community, the more likely the AARC residents will embrace the needs of that community and strive to elevate.

There is a wealth of knowledge, talent and income to be contributed by an AARC community to an established area. If integrated as a welcomed asset, the AARC community will bring varied ideas and improvements.

[16] Diane R. Suchman, *Developing Active Adult Retirement Communities, p.27*

Creating Senior-Friendly Communities: The Role of Government and Community Planners

By

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Denise Boswell, Ph.D.

Creating Senior-Friendly Communities: The Role of Government and Community Planners

Statement of the Issue

In the coming decades, urban planners will be confronted by an unprecedented challenge as American society ages. Not only are there more older people with more to come as the boomer generation ages, but people are also living longer. This trend has enormous implications at the community level, which is where the demand for housing alternatives, transportation assistance, and medical and other support services must be addressed. The ability of a community to respond effectively to these needs will be influenced by how well the concerns and needs of older residents are integrated into physical planning efforts.

Older citizens oftentimes have a distinctive perspective that is overlooked in planning for their communities yet is critical to the well-being of the greater community and to their successful aging experience. By making plans and policies senior-friendly, planners can address the issues and visions of this sector of the population and thereby create more vital and complete living environments – better communities for all people. The underlying philosophy is that *every* community member, regardless of age, should have the opportunity to participate as fully as possible in community life. Most everyone wants to age well and live independently where they have always lived – if not in their own homes, then at least in familiar surroundings. A senior-friendly community recognizes these aspirations and takes steps to make them a reality.

Because of the magnitude and urgency of this issue, it is critical that government take the lead in developing and implementing programs that will ensure that communities will be better able to accommodate older residents throughout the life course. Creating senior-friendly places will take a conscious effort beginning at the national level with states being given the directive to create and execute a senior-friendly communities initiative at local levels. For the success of this important program, it is essential that effective partnering occur among all who are concerned about the well-being of older individuals as well as the well-being of their communities.

Barriers to be Overcome

There are numerous barriers that must be overcome in order for us to act on this issue in a proactive and timely manner. By moving aggressively forward with working through these obstacles, we have an opportunity to prepare our communities – the places and the people – for the inevitable demographic changes that are going to occur. The effect will be to create communities that will encourage and enable people to age in place. This will help ensure intergenerational exchange and a positive living environment for all residents. The major barriers include:

- Prevalence of ageism

- Lack of foresight
- Absence of national policy = lack of state-level initiatives = lack of awareness and impetus on local government level
- Inadequate funding/resources
- Lack of awareness and knowledge by urban planners on their role in making places senior-friendly, the aging process, and the distinctive needs of older adults
- Absence of plans and policies that mandate and encourage age-sensitive planning
- Lack of coordination among planners and aging specialists/service providers
- Lack of understanding by seniors on the important role they can play

Workable Solutions

The eight barriers listed above are, in some cases major and longstanding, but are not insurmountable. The key is to act on overcoming them now, which will require input and cooperation among the various partners. In essence, the overall solution revolves around education and development of effective policy. My experience after researching and writing on this issue for eight years is that, generally, once peoples' consciousness has been raised and they understand the importance of places becoming senior-friendly or more livable for all, there is little descent and question as to why a community should not move in this direction.

Recommendations for Action

The upcoming White House Conference on Aging provides a grand opportunity to establish new and reinforce existing policies relating to the aging of our population. As very few states have implemented an initiative for senior-friendly or livable communities, it is essential that a national policy be adopted requiring all states to immediately develop and implement a program that would move local jurisdictions in this direction. Since it will take time and coordination among various agencies/organizations, it should be expressed as a national priority for the coming decade. This policy would then be carried out by state governments at the local level.

In addition, organizations such as AARP, the National Council on Aging, the Association of Area Agencies on Aging, the American Planning Association, and the Smart Growth Alliance, among others, need to be brought "on board" as to the urgency of the issue and to how we all must work together to bring about an acceptable level of senior-friendliness in our communities.

In other words, an awareness or education campaign has to be developed to inform individuals and groups of what it means to be "senior-friendly", why this is of such importance, and how to develop an effective plan of action.

By mandating that local jurisdictions become more senior-friendly, there is greater likelihood that communities will become more vital and balanced and so better able to accommodate all people regardless of age. It is important to remember that senior-friendly communities = people-friendly places.

Community Forums Report

(J)
Need to Develop Senior Friendly Communities

2005 WHITE HOUSE CONFERENCE ON AGING

COMMUNITY FORUMS

NEED TO DEVELOP SENIOR FRIENDLY COMMUNITIES

LOCATION OF EVENT: Gaillard Municipal Auditorium – Charleston, SC

Priority Issue:
Safe, public transportation services in the Trident area are not affordable, reliable, and accessible to seniors in the rural and urban areas.

Barriers:
1) Lack of funding for liability protection from state and local government.
2) Lack of a safe environment conducive for a public transportation system.
3) Escalating gas prices.

Proposed Solution:
6) Involve the faith-based community to assist in providing transportation to medical and non-medical appointments.
7) Educate the community about the impact that population density has on transportation.
8) Transportation providers should coordinate services to eliminate gaps and duplication in services.
9) Utilize smaller vehicles rather than buses to provide the transportation service.
10) Provide subsidized transportation services through taxi companies.

Recommendation:
A safe public/private transportation system that covers liability and subsidized services for seniors that includes affordable, reliable services to medical/non-medical destinations from rural and urban areas.

LOCATION OF EVENT: Fennell Elementary School - Yemassee, SC

Priority Issue:
Transportation; configuration of senior centers; integration of elderly with non-elderly community; increase opportunities for volunteerism and other forms of civic engagement.

Barriers:
1) Transportation not generally available for seniors in rural areas to allow more social interaction, trips to doctor appointments, shopping, etc.; creates isolation and lowers quality of life for seniors.
2) Insurance premiums to cover volunteers are prohibitive, especially for volunteer drivers of vans and other mobile transportation means.

3) Federal guidelines for Title III funds for senior centers prohibit flexibility in activities and meals to meet the needs of local senior populations.
4) Limited funding prevents staffing for extended hours and different activities.
5) Senior centers have image problems; perceived as for indigent population only.
6) Lack of funding for intergenerational activities in rural areas.
7) Food stamp guidelines not friendly to seniors.
8) Healthier foods beyond financial means of most seniors living on Social Security only.

Proposed Solution(s):

1) Find solution to insurance deterrent to volunteerism so more volunteers will be willing to drive seniors to appointments; extend Good Samaritan Law to cover volunteers.
2) Fund more vans for faith-based community to provide transportation to seniors.
3) Extend federal Title III guidelines for senior centers to allow flexibility of spending to encourage creative use of funds to meet needs of local cultural diversity.
4) Extend administrative funds to allow more staffing hours to accommodate local activities at other than meal times, recognizing seniors of today and tomorrow are more physically active and socially diverse than previous senior populations.
5) Create more aggressive/creative approaches to creating intergenerational activities.
6) Revamp food stamp programs to coordinate with Older Americans Act.
7) Offer weekly Farmers Market vouchers to seniors.

LOCATION OF EVENT: Pinckney Hall, Sun City Hilton Head – Bluffton, SC

Priority Issue:

Transportation; changing attitudes toward aging; construction of senior homes for aging in place; one stop shops.

Barriers:

1) Lack of transportation services in rural areas restrict mobility of seniors after they stop driving; limiting access to services and socialization.
2) Senior population is changing and general population needs to be educated to more active lifestyles of today's and tomorrow's seniors.
3) Not enough affordable, senior-friendly housing and activities available to middle income seniors.
4) Difficulty in accessing services/learning about available services for seniors.

Proposed Solution(s):

1) Form partnerships with faith-based community to provide transportation vans; government supply the minivans and faith-based community provide volunteer drivers.

2) Contract with local taxi services to allow seniors to purchase coupon books at reduced rate for transportation to doctor appointments, shopping, etc. Government could subsidize the coupons to offset revenue loss by taxi services; should be available to all seniors.
3) Uniform Building Code needs to be revised to address mobility issues of seniors and implement requirements to standardize housing to allow aging in place for seniors.
4) Provide tax incentives for home building industry to build handicap-friendly homes.
5) Promote more physical activities for senior center communities to better promote socialization and health lifestyles for seniors.

LOCATION OF EVENT: H. Odell Weeks Activity Center – Aiken, SC

Priority Issue:
Transportation services are not available, affordable, reliable, and/or accessible to seniors in the rural and urban areas. There is also the problem of families not being able to tell their loved ones they can no longer drive safely.

Barriers:
1) Lack of accessible, affordable transportation.
2) Transportation for medical appointments is available only for Medicaid recipients.
3) Seniors live in isolated rural areas.
4) Insurance/liability concerns prevent other agencies from renting their vans to transport seniors.
5) Lack of affordable public transportation. The public transportation in Aiken does not always meet the need.
6) Lack of a system to verify driving skills of seniors who may be a driving hazard.

Proposed Solution(s):
1) Involve the faith-based communities to assist with transportation needs during the week when church vans and buses are not being used.
2) Develop public transportation programs with affordable fares that are accessible to more people.
3) Address rules/regulations and liability issues that prevent organizations from partnering.
4) Address the needs of the "Haves" and "Have Nots" to help close this gap.
5) Develop transportation programs for people who can afford to pay, but can no longer drive.
6) Develop talking points for families, physicians, and law enforcement to talk with persons who can no longer drive safely.

LOCATION OF EVENT: Orangeburg County Council on Aging-Orangeburg, SC

Priority Issue:
Transportation services in Lower Savannah Region are not available, affordable, reliable, or accessible to seniors in the rural and urban areas.

Barriers:
1) Limited access to transportation for appointments, drug stores, grocery shopping, etc., that is affordable.
2) Transportation for medical appointments is available only for the Medicaid recipients.
3) Seniors live in rural isolated areas.
4) Insurance/liability for transportation prevents other agencies from renting their vans to transport seniors.
5) Lack of transportation programs where people can pay an affordable fare for transportation.

Proposed Solution(s):
1) Involve the faith-based communities to assist with transportation needs during the week when church vans and buses are not being used.
2) Develop public transportation programs with affordable fares.
3) Address rules/regulations and liability issues that prevent organizations from partnering.
4) Address the needs of the "Haves" and "Have Nots" to help close this gap.

LOCATION OF EVENT: City Council Chambers – Rock Hill, SC

Priority Issue:
The Catawba region lacks affordable transportation to transport seniors and other vulnerable populations to their desired destinations.

Barriers:
1) Out-migration by younger adults leaves many communities vulnerable.
2) Transportation is not available for socialization and mobility within the community except for doctor visits.
3) No access to mass transit for rural residents.
4) Gaps in general awareness of needs of seniors regarding transportation.
5) Lack of transportation to certain areas.
6) Inaccessibility of Meals on Wheels Programs in general.
7) Reduction in farm subsidies will negatively impact senior population, which forces service providers to prioritize.
8) Confusion exists between Meals on Wheels Programs and nutrition programs provided by Council on Aging organizations in the Catawba region.
9) Always have to balance needs with access to funding.
10) Visibility of services and senior needs.
11) Lack of mobility increases the need to reach out to seniors when family members are not around.
12) Faith community referring seniors but not serving seniors.

Proposed Solution(s):

1) Senior service providers in their communities provide outreach.
2) Explore the possibility of getting volunteer groups to check on seniors to see how they are doing.
3) Blast frozen meals have offered an alternative for meals to those residents living in very rural area.
4) Use of volunteers to deliver meals in York and Union counties helps a great deal.
5) Need to explore ways to reach out to increase the visibility of seniors so that all are aware.

LOCATION OF EVENT: Santee-Lynches Regional Council of Governments – Sumter, SC

Priority Issue:

Transportation

Barriers:

1) Finance.
2) Stops not marked because of state, city, and county legal issues.
3) Cabs are not cost effective, not prompt, not as professional as they should be, and in some cases not as safe as they should be.
4) Demand difference from rural to urban areas.
5) Insufficient marketing/education.
6) Language issues.
7) Territorial boundaries.
8) Seniors not comfortable with the voice automation procedures that are sometimes used to make needed transportation arrangements.

Proposed Solution(s):

1) Educate legislature about needs of transportation, especially about dependent communities.
2) Need for affordable employment transportation network.
3) Providers should be professional and proactive.
4) Routes that are efficient and effective for users.
5) Have authorities support transportation.

LOCATION OF EVENT: Emmanuel Baptist Church – Manning, SC

Priority Issue #1:

Transportation.

Barriers:

1) Lack of available transportation; not enough options/types of vehicles

2) Lack of available transportation to enable seniors to obtain groceries and other needed items, attend church, go on needed errands, go to doctor appointments, and visit friends.
3) Lack of governmental education/knowledge.
4) Lack of support/commitment.
5) Inadequate funding
6) Lack of coordination and efficiency.
7) Fees too high.
8) Insurance issues.

Proposed Solution(s):

1) Establish adequate transportation services; provide affordable, safe (escorted/assisted), reliable, transportation as needed.
2) Increase local, federal and state funding.
3) Increase lobbying efforts.
4) Provide educational forums for community and government.
5) Ensure effective coordination.
6) Use volunteer coordinated transportation from faith-based community and other parts of the community.

Priority Issue #2:

Information and referral/assistance to senior community.

Barriers:

1) Lack of information & access to services/programs.
2) Families spread throughout the globe.
3) Many seniors finding themselves with no surviving family members.
4) Need to promote family values (current values and morals as high as they should be, lack of respect for seniors).
5) Lack of senior community programs and opportunities.

Proposed Solution(s):

1) Better promotion of services available to seniors.
2) Better promotion of senior centers.
3) Provide more inter-generational programs.
4) Expansion/promotion of Foster Grandparent Programs.

LOCATION OF EVENT: Kershaw County Health Resource Center – Camden, SC

Priority Issue #1:

Stay at home to age in place.

Barriers:

1) Lack of convenient services prevent seniors from being able to stay at home.

2) Families not caring for own.
3) People having mentality and dependence on government (common thinking that the "Government will take care of it.")
4) Separation of seniors from extended families because families are now so widespread.
5) Current medical emphasis is on intervention versus prevention.

Proposed Solution(s):

1) Provide additional funding to ensure adequate services.
2) Educate community on the importance of preventive measures.
3) Develop comprehensive community services to help families care for their own.
4) Modify tax structure to benefit elderly.
5) Provide additional services to ensure safety and quality of life of seniors.
6) Refine Social Security to ensure it provides lasting coverage.

Priority Issue #2:

Rural Needs versus Urban Needs

Barriers:

1) There is unfair distinction between rural and urban communities when it comes to funding.
2) There is a lack of distinction between rural and urban communities when it comes to federal and state policies.
3) Rural populations have less voice than urban.
4) Less money for services available to rural communities.
5) Aging population increasing.

Proposed Solution(s):

1) Education in communities as to the difference in needs of a rural and urban population.
2) Provide good management of monies and accountability of spending.
3) Locate a model program for our communities to follow.
4) Educate legislature on the different needs of a rural and urban community.
5) Provide additional federal and state funding of faith-based and non-profit programs so rural areas can receive additional assistance.

Focus Group Concern: (1) Rural versus urban "recreational" needs, (2) Community ADA accessibility, (3) Transportation needs in rural and urban communities, (4) Establishing safe communities, (5) Taxes should be better adjusted especially for those on a fixed income, (6) Senior counseling and a One-Stop Information Center should be made available to seniors, and (7) More involvement and more funding for community and faith-based organizations.

LOCATION OF EVENT: The Shepherd's Center – Sumter, SC

Priority Issue:
The need for information and referral services.

Barriers:
1) Not enough marketing.
2) Insufficient transportation options to receive needed services.
3) Insufficient sharing of information among agencies.
4) Turf war exists among some service agencies.

Proposed Solution(s):
1) Additional marketing beginning at the grass root level.
2) Establish a strong volunteer base.
3) Establish more options for affordable and reliable transportation.

LOCATION OF EVENT: Bethlehem United Methodist Church – Bishopville, SC

Priority Issue #1:
One-Stop Information Center.

Barriers:
1) Lack of marketing of information.
2) Agency "turf wars."
3) Limited capacity.
4) Lack of technology.
5) Lack of human interaction; many seniors do not like to use "automated" services.
6) Limited education of those needing services.
7) Lack of options.
8) General attitude of "let someone else do it."

Proposed Solution(s):
1) Increase marketing efforts.
2) Increase funding.
3) Coordinate service efforts at local, state, and federal levels.
4) Educate public on purpose to serve to increase volunteers; it should be considered a moral obligation.

Priority Issue #2:
Access to healthcare.

Barriers:
1) Lack of transportation.
2) Lack of regional representation on boards.
3) Areas having a small population density do not get required support or funds; it's a numbers game.
4) Insufficient planning to address healthcare issues and no follow-up.

5) Need for additional medical screenings to prevent healthcare problems.

Proposed Solution(s):
1) Develop a legislative coalition to ensure adequate funding of healthcare, transportation and planning, especially for rural areas.
2) Consider using mobile screening units to access rural areas.

Focus Group Concern: (1) Need for quality ADA housing, (2) Need for adequate, safe, and secure communities, and (3) Need for developing a senior friendly, "walkable" community.

LOCATION OF EVENT: Upper Savannah AAA – Greenwood, SC

Priority Issue:
Information services in one place (One-Stop concept); transportation.

Barriers:
1) Communication.
2) Transportation.
3) Lack of resources.

Proposed Solution(s):
1) Packages for newcomers to our communities that provide information on services that are available in the area.
2) Community programs that address senior related issues.
3) Use churches to provide transportation to seniors, i.e., church established fund to pay unemployed church members to drive shut-in church members to medical appointments.